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National Child and Adolescent Mental Health Service Mapping Exercise 2005

Di Barnes, Richard Wistow, Richard Dean with Bob Foster



Foreword

The Government is committed to improving Child and Adolescent Mental Health Services (CAMHS) so that high quality and responsive services are available to all who need them. In order to achieve this aim, it is essential that policy makers and service planners have access to comprehensive and accurate data on current service provision. CAMHS Mapping provides this information. We are delighted, on behalf of both our Departments, to commend this fourth atlas of mapping information to all those with an interest in the development of CAMHS.

CAMHS Mapping has proved to be a valuable tool in tracking progress towards the objective of comprehensive CAMHS available to all. Although there is clearly still much to do, it is sometimes easy to forget the significant progress that has been made in recent years. To give some examples, the reported spend on CAMHS has increased from £284M in 2002 to £513 in 2005, the CAMHS workforce has increased from 7300 to 9900, and the number of teams from 732 to 1051 over the same period. There have also been impressive increases in the number of CAMHS offering specialist care to children with a learning disability, and emergency call out arrangements are much improved. The number of children and adolescents being seen and treated by specialist CAMHS has increased by 8 per cent in the last year and by 30 per cent since 2003. Waiting times for longer waits are down, although short-term waits have increased due to the larger number of patients seeking to access services. Overall, the year-on-year comparisons between 2004 and 2005 are very encouraging and reflect a picture of genuine service improvement.

However, despite these improvements there are still considerable variations across England in the availability of different aspects of service and the length of wait to access them. CAMHS Mapping makes these differences transparent and is therefore a useful tool to drive up standards in those areas that most need to improve. It will be important, therefore for all those involved in the commissioning of children's services to consolidate the improvements that have been made while seeking to develop those areas of service which remain unsatisfactory.

Finally, we would like to thank all those who provided the data, as well as those at Durham University and in our respective Departments who managed the mapping exercise and contributed towards this publication.



Sheila Shribman

*National Clinical Director for Children's Health Services
Department of Health*



Naomi Eisenstadt

Chief Adviser on Children's Services to the Department for Education and Skills

Introduction

Overview

This atlas presents the findings of the fourth National Child and Adolescent Mental Health Service (CAMHS) mapping exercise. This was carried out between October 2005 and February 2006 in three parts. Firstly, in the service mapping element of the exercise, the inventory of specialist CAMHS provision built up since 2002 and led by mental health provider NHS trusts, was updated to reflect the state of service provision in November 2005. Secondly, financial mapping was completed by PCT commissioners to record their actual CAMHS budget for 2004/5 and their predicted budget for 2005/6. Thirdly, local authority commissioners were asked to complete a parallel finance mapping exercise and, for the first time, to submit data on a number of performance measures for use by the Commission for Social Care Inspection (CSCI).

As in previous years, the 2005 CAMHS mapping data was used for performance measurement purposes by both the Healthcare Commission and the Department of Health. This was the third year of the performance programme of the PSA targets (2003-6) aimed at achieving growth in CAMHS around the country. The mapping data was used to provide evidence of increases in CAMHS, measured in terms of changes in annual investment, staffing levels or caseload. As this report demonstrates, very positive results were found and it is hoped that by increasing awareness of CAMHS provision and investment on an on-going basis through the provision of information, the mapping exercise has made a contribution to this successful growth over the last three years.

Aims

CAMHS mapping focuses on the provision and commissioning of specialist services defined as tiers 2-4 services in 'A Handbook on Child and Adolescent Mental Health', (Dept. of Health, 1995), 'Together We Stand', (NHS Health Advisory Service, 1995) and updated in Standard 9 of the Children's National Service Framework (CNSF), 2004 [set out in annex 1].

CAMHS mapping aims to:

- Support the development of the Children's National Service Framework (CNSF) and to contribute to the monitoring of progress in its implementation;
- Provide comparative data on the progress in achieving service frameworks and delivery plan targets for the range of inspectorial and supervisory bodies which support the commissioning of CAMHS;
- Assist in the bid for resources for CAMHS development;
- Support local service development and gaps analysis;
- Facilitate local benchmarking.

The mapping exercise results in a national service overview, indicating what is provided, where, and with what levels of investment. A very large quantity of data was collected in 2005 summarising the work of over 1,000 CAMHS teams employing almost 9,900 whole time equivalent staff (WTE) caring for around 113,000 children and young people in the mapping sample period, at the cost of £513 million. It is not possible to report all the findings in a single report and so this atlas reports only at a National and Strategic Health Authority level. More local findings can be found on the website and reference is made to this within each of the Atlas chapters. As the mapping was carried out in 2005, the SHA boundaries in place at that time have been used.

Management arrangements

CAMHS mapping was undertaken by the Durham Mapping Team which is based in the School for Applied Social Sciences at Durham University. The team first developed the service mapping methodology in 2000 to monitor progress in the implementation of the Mental Health NSF and since then annual mapping exercises have been introduced for CAMHS, child health services and older people's mental health services.

CAMHS mapping was developed in partnership with the CAMHS policy branch at the Department of Health and the Durham Mapping Team continues to work in close collaboration with the National CAMHS Support Service (NCSS) which is part of the Care Services Improvement Partnership (CSIP). The exercise has been advised and approved by a National Advisory Group made up of practitioners, managers and policy makers who provide a wide representation of agencies and disciplines in the CAMHS field. The CAMHS mapping exercise is signed off by the National CAMHS Information and Mapping Sub-Group which is accountable to the joint DH and DfES CAMHS Project Board. The approval of the Review of Central Returns (ROCR) at the Department of Health was granted in September 2005 for the most recent exercise.

Methodology

A new website was set up for CAMHS mapping in 2005 at www.camhsmapping.org.uk/2005. This site contains facilities for the three areas of data collection; service mapping, finance mapping by PCTs and finance and PI mapping by local authorities. In addition, the website contains reports of the findings and links to previous mapping exercises.

As the CAMHS mapping is in its fourth annual data collection cycle, the web-based mapping process has become familiar to the majority of services involved. By and large, the national inventory of services has now been created and requires only revision and update each year. However, the work involved in this data update is considerable. Staffing information has to be checked, caseload numbers have to be counted and details of the type of service delivered have to be revised. It is thanks to the thorough way that this data has been submitted each year that it has been possible to trace the significant growth in CAMHS provision reported in this document.

Key stages in the service mapping process are as follows:

- Within each NHS trust providing CAMHS tier 2-4 teams, a Head of Service (HoS) is nominated to take responsibility for collecting the data on the services provided in their area. HoS were asked to register on the mapping website, identify the catchment/partnership area for their local services and co-ordinate data entry, working with PCT, LA and voluntary sector partners where appropriate;
- For all teams delivering tier 2-4 CAMHS, details of their provision, function, specialisation, staffing and activity are requested. Some details of the characteristics of the children and young people CAMHS staff worked with are also needed. All data are input on-line although the website provides printable documents which can be used to collect the information if local information systems are inadequate for this purpose;
- All data must be entered by 28th February and 'signed off' as correct by the Chief Executive of the NHS provider trust.

PCT commissioners were required to register on the website and submit data on their CAMHS budget for the last and current financial year, distinguishing how much of the budget was spent with each of their service providers. PCT commissioners were identified with the help of SHA CAMHS Leads and their support throughout the exercise was much appreciated. As with service providers, PCT Chief Executives were requested to confirm agreement with the data submitted by signing it off before the February deadline.

Local authority commissioners were identified with the help of CSCI and DfES. The commissioners were asked to register directly on the website and provide two types of data. First they were asked to submit financial data on local authority CAMHS budgets and secondly they were asked to state the progress of their authority in meeting a series of national targets on CAMHS provision. These will be used for local authority performance rating purposes in November 2006.

The mapping databases were frozen on 28th February 2006 and a copy of the data on investment, staffing and caseload numbers was sent to the Healthcare Commission. Local authority data was sent to CSCI.

A helpdesk operated throughout the mapping period and could be contacted by phone or email. Very good use was made of this facility and valuable feedback was received by the Durham Mapping Team which will inform improvements in the 2006 exercise.

Terminology

Definitions of the terms used in the Atlas are provided in the relevant chapters but special note should be taken of terms used to describe teams as there are two important distinctions. CAMHS teams are usually described within the tier 1-4 typology. However, in the development of the CAMHS mapping, it was found that the tier system was not enough to denote the structure and function of the teams and so a team type was created to provide a short-hand team descriptor.

The types that evolved from the pilot and first CAMHS mapping exercises were: generic teams (both multi and single discipline); targeted teams; dedicated CAMHS worker teams; and special care teams. Broadly, the first three team types equate to tiers 2/3 and special care teams equate to tier 4. As the activity of tier 4 teams has been collected differently from the rest – again in response to feedback from the field during the first two mapping exercises – it is not always possible to report ‘all teams’ together. Therefore, when activity is reported, tier 2/3 teams have been described separately from tier 4 teams.

The second way that CAMHS teams have been described is to identify local teams and those that serve a wider than local catchment area which may be a number of Strategic Health Authority (SHA) areas or even the whole country. This distinction is important as CAMHS policy stresses the need for local integrated care for children and young people in which partner agencies work together to meet local need as close to where people live as possible. However, there is not a complete match between tiers 2-4 and local and wider teams. The match is good between local and tier 2/3 teams with 95% falling into both categories but for wider than local teams the match is not as strong. Only 65% of wider teams are also tier 4 teams, the other 35% (40 teams) are described as tier 2/3. Therefore within the Atlas, the two parallel ways of describing CAMHS teams are used.

Using this atlas

The structure of the 2004 CAMHS Mapping Atlas has been adopted again for this report as this was based on the policy designed to deliver a comprehensive CAMHS as set out in the Children's National Service Framework (CNSF). The structure is as follows:

In more detail:

Chapter 1:	provides a summary of the key national messages on the achievement of both Performance Indicators and aspects of a comprehensive CAMHS service. It serves as an executive summary from which policy makers and managers should derive key national messages
Chapter 2:	sets out the elements of a comprehensive CAMHS service mapped, highlighting elements of services such as team types, on call, learning disability services and the suitability of services for 16-18 year olds
Chapter 3:	sets out national progress against the performance indicator on spend
Chapter 4:	sets out national progress against the performance indicator on activity
Chapter 5:	sets out national progress against the performance indicator on workforce
Chapter 6:	discusses the technical aspects of the exercise including quality checks.

Local access to data

The Durham Mapping Team is continuing to develop the ways it reports mapping data and to provide tools with which the data can be interrogated. National, regional and local reports are available on the website and a new service directory has been set up which enables users to search for team descriptions at a local or national level. If you have any difficulties using the reports, or have requests for data that you need, please contact the team.

The website can be found at: www.camhsmapping.org.uk/2005 and the Mapping Team can be contacted at: help@camhsmapping.org.uk

Note on accuracy

The data reported to the Healthcare Commission, although signed off and error checked still had some rogue results, which were further followed up by the team for the purpose of the Atlas. This Atlas therefore reports some results that were not those submitted to the Healthcare Commission. The on-line tables are programmed so that both copies of the database can be viewed.

Chapter 1:

A Summary of National Trends

The fourth national CAMHS mapping exercise was carried out between November 2005 and February 2006 to record the provision of tier 2 to 4 CAMHS in England. The aim of the mapping was to monitor progress in the implementation of the Children's National Service Framework (CNSF) and subsequent policy guidance and to develop a dataset that is of use to service planners and commissioners locally. For the last 3 years mapping data has also been used for performance measurement purposes, providing evidence of the achievement of national PSA targets for CAMHS indicated through increases in investment, workforce and activity.

Key messages from the 2005/6 CAMHS mapping are set out as follows:

- 1.1 Changes to registered services**
- 1.2 CAMHS team development**
- 1.3 Evidence of comprehensive CAMHS**
- 1.4 Investment**
- 1.5 Activity**
- 1.6 Workforce**

Comparisons are made with the findings of the last two years wherever possible so that trends can be demonstrated. No reference is made to the 2002 mapping findings as this was the first year of the exercise, it was still developing and therefore the accuracy of data was less reliable.

Detailed tables of the data used can be found and downloaded from the CAMHS mapping website at:

www.camhsmapping.org.uk/2005



1.1 Registered Services

148 services returned mapping data in 2005, 139 services were returned in 2004. Two services in the 2004 data returns merged into one in 2005, leaving a further ten services that were new to the mapping. These new registrations covered a number of individual teams which chose to map alone rather than negotiate inclusion into their locality map.

Fig. 1.2a: Trends in local and wider teams

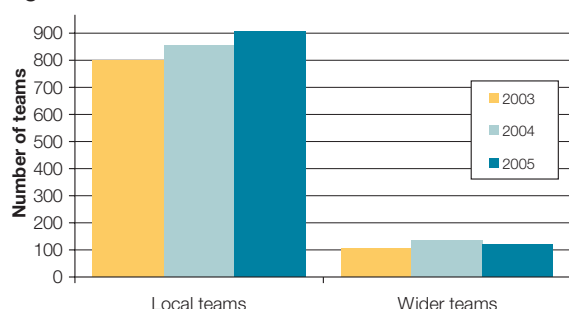


Fig. 1.2b: Changes to the teams mapped 2004 to 2005

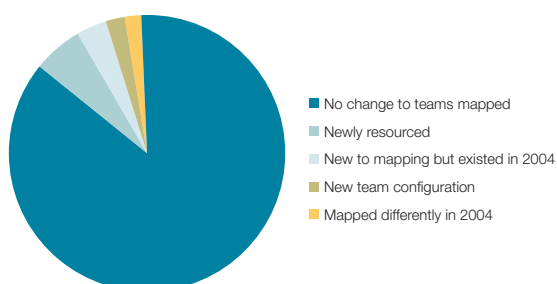
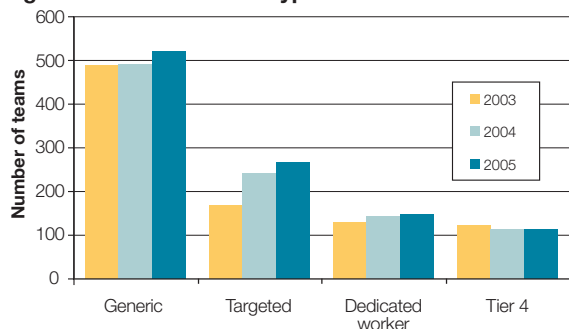


Fig. 1.3a: Trends in team type



1.2 Team development

- The total number of teams mapped in 2005 was 1051. This marked an increase of 16% on the 909 teams reported in 2003.
- A steady increase in the number of local teams was reported over the three years 2003 to 2005 (Fig. 1.2a). These are teams that serve a defined local area. Numbers rose from 801 in 2003 to 854 in 2004, and to 932 in 2005, a 3-year increase of 16%.
- The number of teams serving a wider area, including regional and national services showed fluctuations in the mapping but the changes could be attributed to the way services defined 'local' geography. Wider than local teams increased from 104 to 135 between 2003 and 2004, but decreased to 119 by 2005.
- Of the 1051 teams mapped in 2005, 908 teams (86%) had been mapped the previous year (Fig. 1.2b). This showed a more stable situation in CAMHS in 2005 than in 2004 when 76% of teams had been mapped as before. In 2005, only 62 (6%) of teams had been newly resourced whereas the proportion of newly funded teams in 2004 had been 10%. A further 38 teams (4%) were new to the mapping but were not new teams on the ground. 22 teams (2%) were mapped differently because of the reconfiguration of local resources, while the mapping of 21 teams (2%) was changed to improve the accuracy of the data recorded.

1.3 Comprehensive CAMHS provision

1.3.1 Team types

- Continued, but steady growth was demonstrated in all team types except tier 4 teams (Fig. 1.3a & b).
- The number of generic teams grew by 30 (6%) while staffing in generic teams increased by 589 whole time equivalents (WTE) (11% of total staff).

Fig. 1.3b: Trends in team type staffing

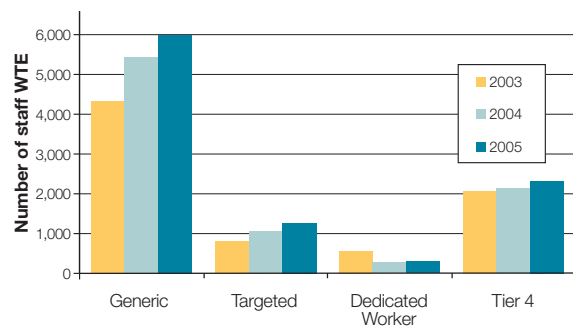


Fig. 1.3c: Type of teams newly resourced in 2004 (N=62)

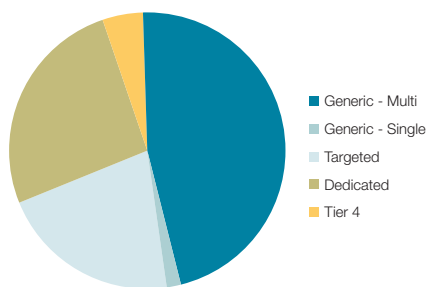
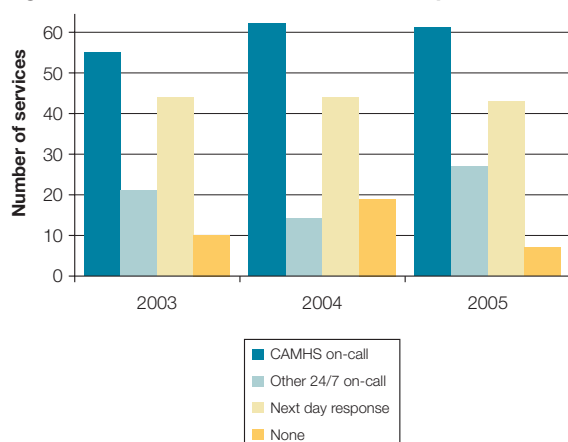


Fig. 1.3d: Trends in CAMHS on-call 24/7 provision



- In the 3-year period 2003 to 2005 generic team staffing rose by 39%. (Fig. 1.3a & b).
- The number of targeted teams increased from 167 in 2003 to 267 in 2005 (60%). In the same period staffing increased by 454 WTE (56%).
- The number of dedicated CAMHS workers who work in non-CAMHS teams also increased by 21 (16%) between 2003 and 2005. There was a 7% growth in dedicated workers between 2004 and 2005. The drop in staff numbers in these teams shown prior to that was due to mapping inaccuracies. Significant improvements were made to how these teams were reported in 2004.
- Of the teams receiving new investment, 49% were generic teams, 26% were dedicated worker teams and 21% were targeted teams (Fig. 1.3c). Only one of the newly resourced teams was generic single disciplinary – a single-worker service currently.
- There was only small growth in tier 4 teams during 2004. Staffing increased by 7%, and only 5% of new investment was made in this area of provision.

1.3.2 On-call provision

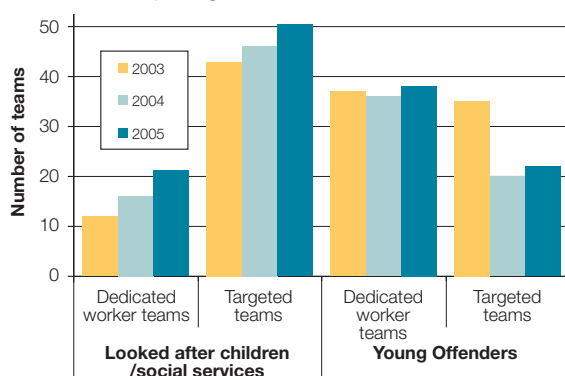
- Overall 88 services (64%) had an on-call service 24/7 but only 61 of these (44% of all services) had on-call provision that provided a response by CAMHS professionals. The number of services with a specialist 24/7 response declined by one owing to a merger of two services since 2004 (Fig. 1.3d).
- Overall, the number of services with either specialist or non-specialist on-call provision rose from 78 in 2004 to 88 in 2005. This meant that 50 services (36%) had no 24/7 on-call.
- Of the services which did not have an on-call service, 43 provided next working day emergency response by CAMHS professionals¹. This left only 7 CAMHS with no specific CAMHS emergency response, a reduction from 19 services in 2004. Three of these services were specialist tier 4 services that would operate 24 hours and would not be expected to have their own separate on-call provision. The remaining 4 services were relatively small providers operating in areas that were covered by larger trusts that provided some form of on-call or next working day response.

¹ If a service provides an on-call service they are not asked whether they provide a next day response. However, 15 services with on-call indicated that they also provided a next day response; these services are excluded from this analysis.

1.3.3 Learning disabilities services

- There was strong growth in the number of services providing specialist provision for children and young people with both learning disabilities and mental health problems. The number of services rose from 48 in 2003 to 62 in 2004 and 68 in 2005. This showed considerable investment in these specialist services over the 24 month period.
- The caseload of CAMHS during the mapping period included 9,538 children and young people with learning disabilities, 526 of whom were cared for by tier 4 teams. In 2004 there were 8,764 learning disability cases recorded showing an increase of 774 (9%) in the numbers of children and young people with learning disabilities supported. In both 2004 and 2005, the share of the total CAMHS caseload with learning disabilities was 8%.

Fig. 1.3e: Trends in focus on looked after children and young offenders



1.3.4 Services for looked after children

- A total of 9,745 looked after children were cared for by CAMHS during the mapping data collection period. This was 9% of the total CAMHS caseload in 2005, a 15% increase on the number the previous year (1,297 cases). DfES statistics show that there were 60,900 looked after children in England as at 31.3.05², with 10,800 of these children over 16 years of age. This means that 1 in every 6.2 looked after child was seen by CAMHS in the sample period in 2005. The comparative figure for 2002 was 1 looked after child seen by CAMHS for every 8.6 in England, showing that the proportion of looked after children being seen by CAMHS is increasing.

- The number of CAMHS teams providing a focus on social services/looked after children increased³. 53 targeted teams (46 in 2004) and 21 dedicated worker teams (16 in 2004) reported a focus on social services work (Fig. 1.3e)⁴.

1.3.5 Services for young offenders

- 5,645 young offenders received care from CAMHS during the mapping period (one month for tier 2/3 only), 5% of the total caseload. This was the same proportion of the caseload as in 2004, but an increase of 472 individual cases. For comparison, there were 195,483 national disposals⁵ in the financial year 2004/5⁶.
- Overall there was an increase of 9% in the number of teams specifically targeting support for young offenders (Fig. 1.3e). These included 22 targeted teams and 38 dedicated CAMHS workers working in non-CAMHS teams. This reversed the trend observed the previous year⁷.

² From DfES, Children Looked After in England (Including adoptions and care leavers), 2004-05. <http://www.dfes.gov.uk/rsgateway/DB/SFR/s000615/SFR51-2005.pdf>

³ This includes targeted teams classified as social services/looked after children and dedicated CAMHS workers in non-CAMHS teams classified as social services

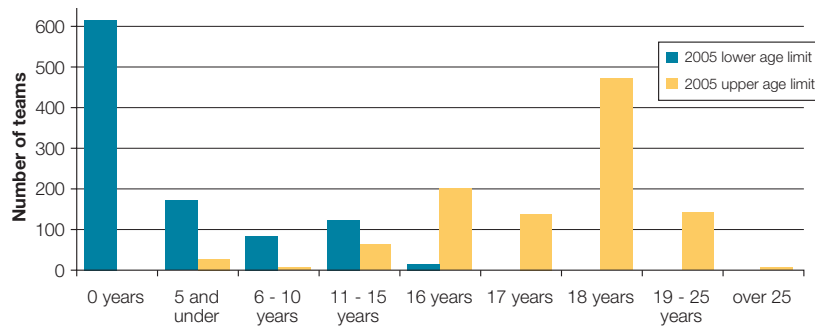
⁴ A LAC report will be published on the mapping website in the autumn of 2006, exploring in more detail provision to local geography

⁵ Defined as all pre-court, first-tier, community and custodial disposals given during the financial year 2004/05

⁶ From Youth Justice Board, Youth Justice Annual Statistics 2004/5. <http://www.youth-justice-board.gov.uk/Publications/Downloads/YJB%20Annual%20Stats%202004-2005.pdf>

⁷ A YOT report will be also published on the mapping website by the autumn of 2006, exploring in more detail provision to local geography

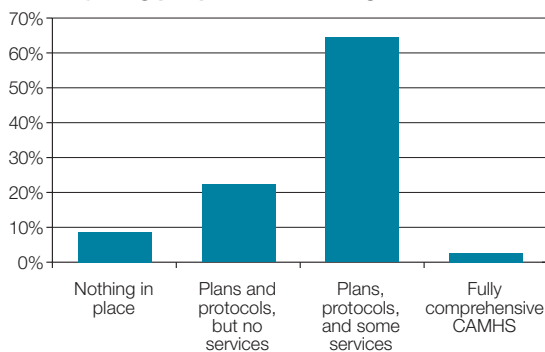
Fig. 1.3f: Upper and lower age limit of CAMHS provision



1.3.6 Services for 16 and 17 year olds

- In 2005 all registered services were asked to indicate if they had services for 16 and 17 year olds that were appropriate for their age and level of maturity. Overall, 55% of responding services reported appropriate provision and 32% of CAMHS teams were identified as providing specialist services for 16 and 17 year olds.
- 19% of teams reported a maximum age limit of 16, declining from 21% of teams in 2004 (Fig. 1.3f). 13% of teams had a maximum age limit of 17, 14% in 2004, whilst 59% of teams had an upper age limit of 18 or above, 55% in 2004.

Fig. 1.3g: LA provision of CAMHS for children and young people with learning disabilities



1.3.7 Local authority provision

For the first time local authorities were asked four questions about the availability of services within their council area, as at 31st January 2006. A response rate of 98% was achieved (N=150).

In total, 4 local authorities (3%) reported that they had a fully comprehensive CAMHS for children with learning disabilities and mental health needs, covering the whole council area. 96 local authorities (64%) had plans and protocols and some services in place, but services still needed to be developed to cover the whole council area. 33 local authorities (22%) had plans and protocols in place, but no services. 13 local authorities (9%) had no CAMHS provision in place for children and young people with learning disabilities (Fig. 1.3g). Four councils did not provide data.

Fig. 1.3h: LA provision of CAMHS appropriate for 16 and 17 year olds

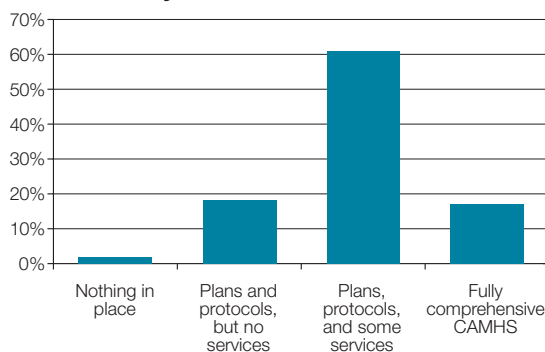


Fig. 1.3i: LA arrangements to meet urgent mental health needs of children and young people

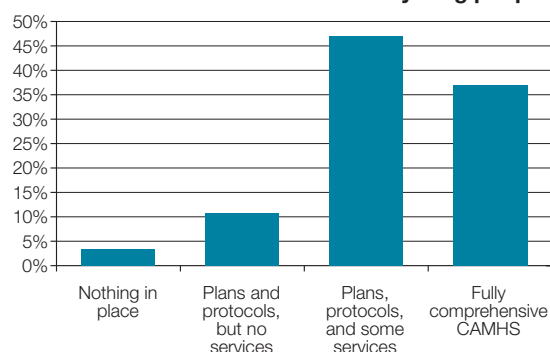
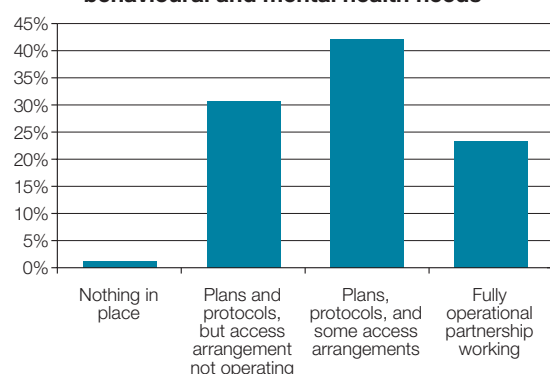


Fig. 1.3j: LA arrangements for partnership working between agencies for children and young people with complex, persistent and severe behavioural and mental health needs

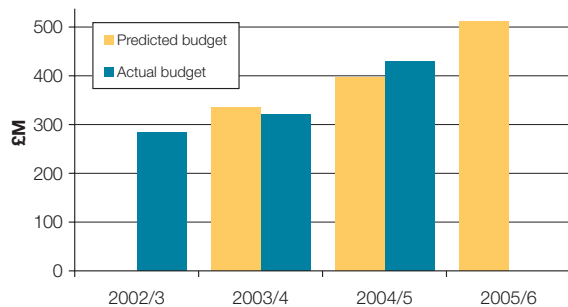


In terms of provision of services to 16 and 17 year olds who require mental health services appropriate to their age and level of maturity, 25 (17%) local authorities reported that they had fully comprehensive CAMHS for 16 and 17 year olds across the whole council area (Fig.1.3h). 91 (61%) local authorities had plans, protocols and some services, 27 (18%) had plans and protocols, but no services and 3 local authorities (2%) had nothing in place. Four councils did not provide data.

Local authorities were asked about the arrangements they had in place to ensure that 24 hour cover is available to meet urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated. 5 local authorities (3%) were yet to address the need for 24/7 cover in their strategic plans; 16 (11%) reported that they had plans and protocols, but no services in place, 70 (47%) had plans, protocols and partially implemented services; whilst, 55 (37%) had fully implemented on-call services covering their whole area (Fig. 1.3i).

Finally, local authorities were asked about the protocols that they had in place for partnership working between agencies for children and young people with complex, persistent and severe behavioural and mental health needs. 35 (23%) local authorities reported that they had fully operational partnership arrangements (Fig. 1.3j). 63 (42%) had plans and protocols in place and with some access arrangements operating, but these did not work across the whole council area. 46 (31%) had plans and protocols at an early stage of development, but with no agreed access arrangements operating and 2 local authorities (1%) had no protocols or partnership services in place. Four councils did not provide data.

Fig. 1.4: Predicted and actual spend on CAMHS 2003-2005



- The commissioning budget of PCTs was £359,902k in 2004/5 rising to £417,854k in 2005/6, an increase of 16%.
- The local authority budget for commissioning CAMHS was £71,324k in 2004/5 rising to £95,615k in 2005/6, an increase of 34%.
- Budgeted spend per 0-17 child and adolescent was £38.91 in 2004/5 but this had risen to £46.33 in 2005/6.
- Adjusting to 2005/6 prices using the PSSRU hospital and community services pay and prices index⁸, the actual spend on CAMHS for 2004/5 was £443,732k. In 2005, accounting for inflation, the increase in investment between 2004/5 to 2005/6 was 16%.

1.4 Investment in CAMHS

- Budgets for expenditure on CAMHS were found to have risen by 19% between the financial years 2004/5 and 2005/6. Although this indicated substantial growth in planned investment in CAMHS, the rate of growth had slowed from 24% the previous year (Fig. 1.4). Following on from an 18% increase mapped in 2003 it is clear that the PSA target of 10% annual growth in CAMHS investment has been far exceeded.
- Actual spend on CAMHS was £431,227k in 2004/5. The predicted spend in 2005/6 was £513,469k.

1.5 Activity

Fig. 1.5a: Trends in number of cases seen and waiting

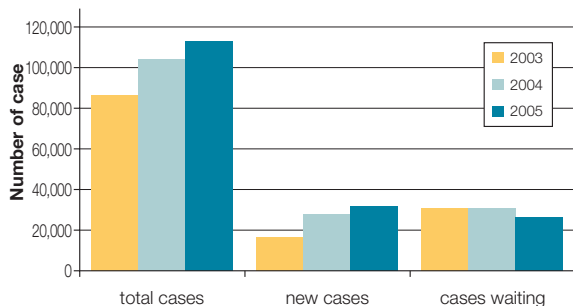
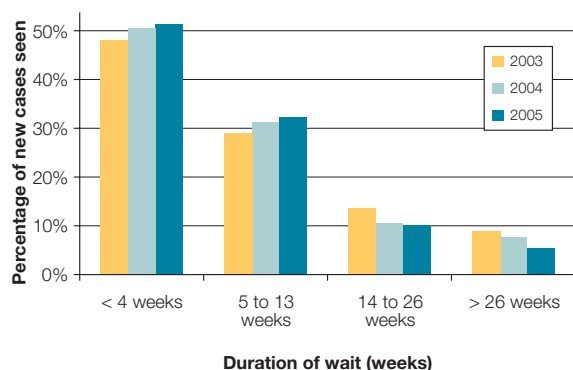


Fig. 1.5b: Trends in length of wait for new cases seen



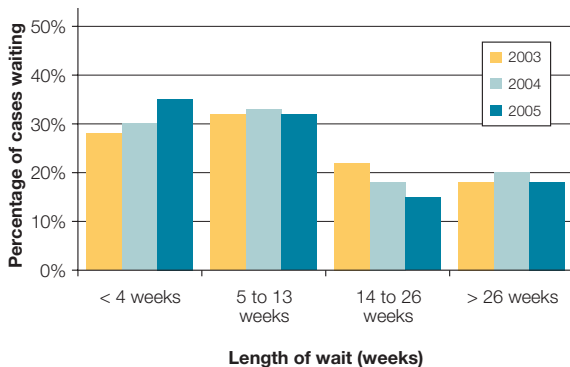
1.5.1 Caseload numbers

- Total caseload of services recorded during the mapping period in 2005 was 112,984, an increase of 8,240 cases (8%) from 104,744 cases in 2004. In 2004 an increase of 18,223 (21%) was recorded (Fig. 1.5a). This gave a cumulative increase of 31% between 2003 and 2005 caseloads indicating that the PSA target of a 10% annual growth in activity was achieved over this period.
- The number of new cases seen in the data collection period in 2005 was 31,330, a rise of 12% on the 27,892 new cases seen in 2004. 16,373 of the new cases (52%) had waited 4 weeks or less and an additional 10,107 cases (33%) had waited less than 3 months (Fig. 1.5b)⁹. The number of cases that had waited up to 6 months showed an increase but this was because the number of new cases seen had risen (Fig. 1.5b). For waits over 3 months the downward trend reported in 2004 continued. In total 4,850 cases had waited more than 13 weeks and of these 3,158 (10%) had waited up to 6 months and 1,692 (5%) had waited over 6 months.

⁸ At the time of going to print the 2005/6 figure was an estimate given through a personal correspondence from Curtis L, PSSRU, University of Kent, Canterbury

⁹ A new case was an active case that had been seen for the first time during the data collection period

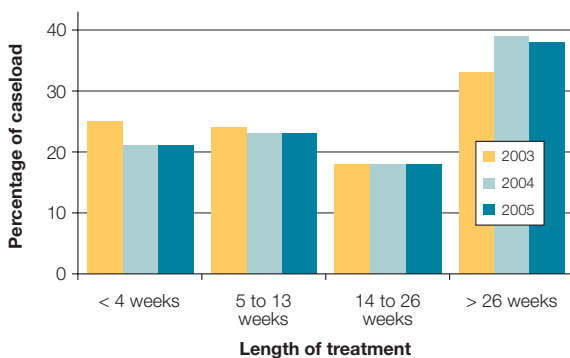
Fig. 1.5c: Trends in length of wait for cases still waiting



1.5.2 Waiting times

- At the end of the 2005 data collection period there were 26,207 cases still waiting, a drop of 2,674 from the previous year. The number of cases waiting for up to 4 weeks continued to rise due to increased demand for services but the numbers waiting longer were down (Fig. 1.5c).

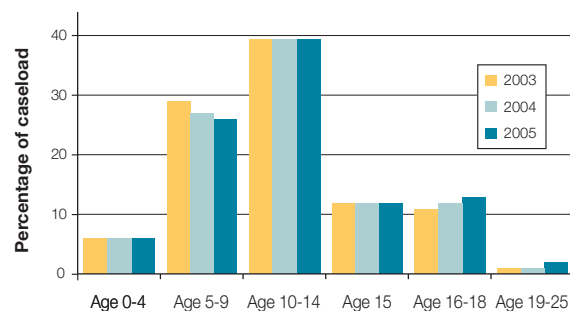
Fig. 1.5d: Trends in length of treatment



1.5.3 Length of treatment

- Length of treatment remained constant except for a small fall in the number of cases receiving treatment for more than 6 months (Fig. 1.5d)¹⁰.

Fig. 1.5e: Trends in age of CAMHS caseload in tier 2/3 teams

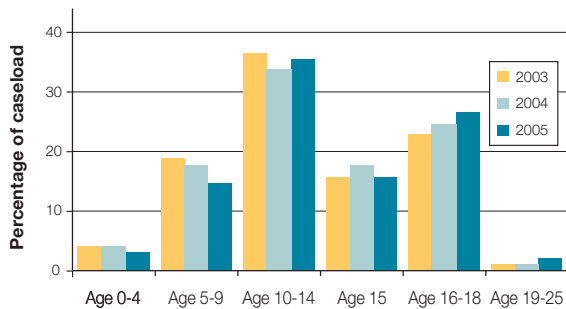


1.5.4 Age profile

- As in 2004 the age profile of the caseload showed a slight increase in the percentage of older children being seen in CAMHS and a decrease in the proportion of children seen aged 5-9 (Fig. 1.5e and f).
- Within tier 2/3 CAMHS the number of 16-18 year olds increased from 10,954 in 2004 to 14,175 in 2005, moving from 12% of the total tier 2/3 caseload to 13% (Fig 1.5e).

¹⁰ Duration of treatment measures how long a case had been seen for, or, if the case was closed in the sample period, how long that case had been active. This was reported from the date the case was first worked with up until 30th November 2005, or until the case was closed.

Fig. 1.5f: Trends in age of CAMHS caseload in tier 4 teams



- The number of 19-25 year olds increased from 725 in 2004 to 1,926 in 2005, moving from a 1% share of the caseload to a 2% share. The tier 4 caseload exhibited similar trends, with 16-18 year olds moving from a 25% share of the caseload to a 27% share (Fig 1.5f).
- Fig. 1.5g compares the age of the total CAMHS caseload during the sample period in 2005 to 2001 census data.

Fig. 1.5g: Age of total CAMHS caseload compared to age groups in England population

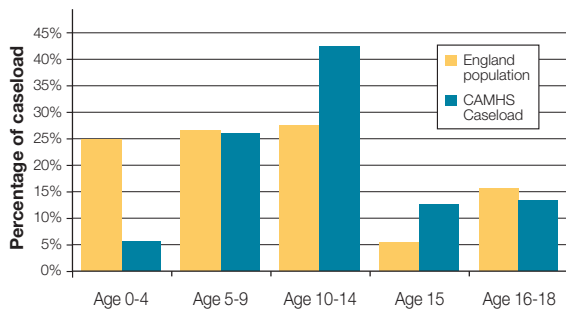
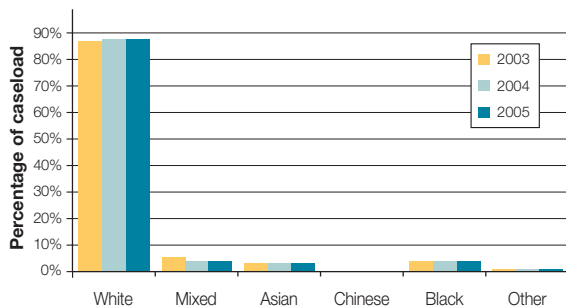


Fig. 1.5h: Trends in ethnicity of CAMHS caseload

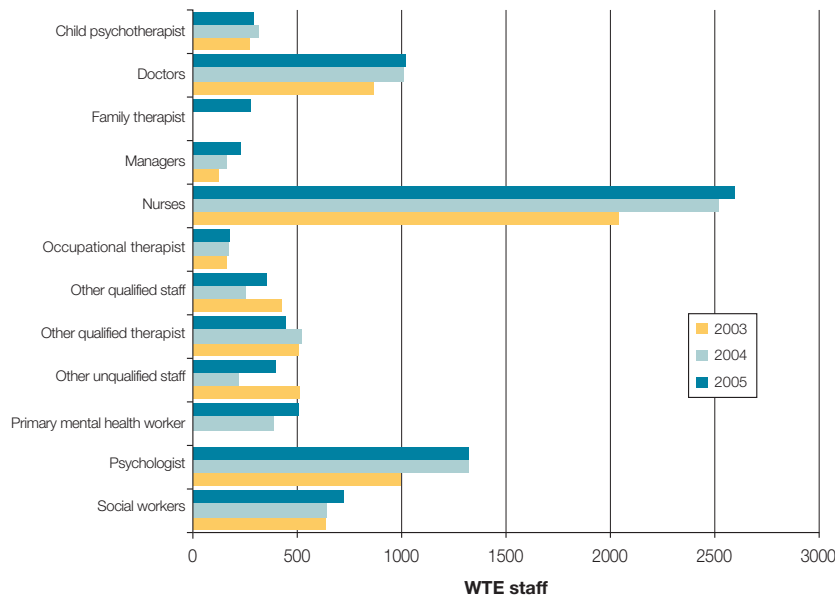


1.5.5 Ethnicity

- The proportion of the caseload whose ethnicity was 'not stated' continued to increase, from 2% of the caseload in 2003, to 8% in 2004, and 10% in 2005.
- Of the remaining cases, 88% of cases of CAMHS teams were of white British origin. The proportions of cases from Black and minority ethnic communities were 3% Asian, 4% Black African, Caribbean and Black British, 4% of mixed race and 1% other.

1.6 Workforce

Fig. 1.6: Trends in CAMHS workforce



Note: Family therapists were only mapped in 2005 and Primary Mental Health Workers were mapped from 2004.

- The total number of staff employed in CAMHS teams increased from 8,892 WTE in 2004 to 9,876 WTE in 2005, an increase of 11%. 7,761 WTE were recorded in 2003, giving growth of 15% between 2003 and 2004, the PSA target of 10% increase in CAMHS workforce year on year was not only achieved but exceeded.
- The number of doctors increased by 1% from 1,008 in 2004 to 1,019 in 2005. This was a considerably smaller growth than that between 2003 and 2004 when the increase had been 16%.
- Similarly the number of psychologists working in CAMHS teams showed little increase between 2004 and 2005 whereas between 2003 and 2004, an increase of 33% was recorded (Fig. 1.6). This workforce category includes clinical and educational psychologists.
- The nursing workforce increased from 2,516 in 2004 to 2,600 in 2005, an increase of 3%. This showed a considerable drop on the 23.5% increase between 2003 and 2004.
- Primary Mental Health Workers were mapped for the first time in 2004 and their numbers grew by 33% from 362 in 2004 to 506 in 2005. In the 2003 exercise PMHWs may have been mapped against other core professions.
- The social worker workforce increased from 638 in 2003 to 640 in 2004 and 722 in 2005, a 13% increase between 2003 and 2005.

Chapter 2:

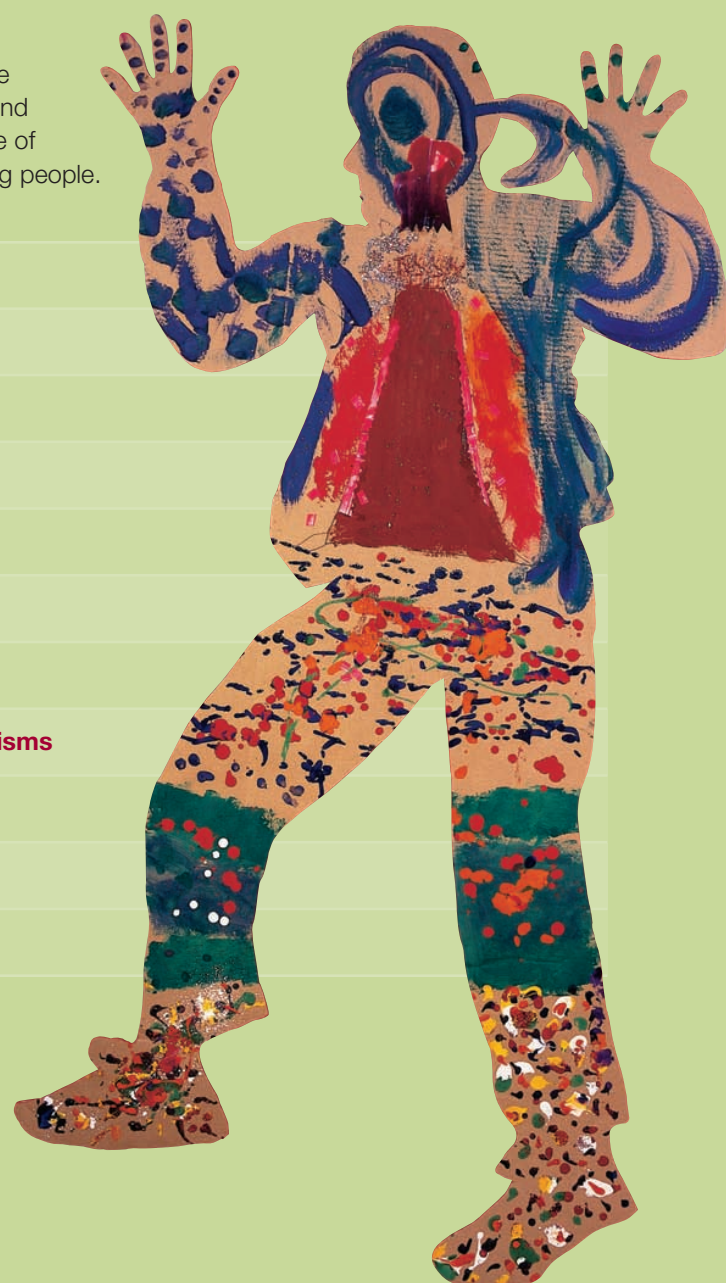
Aspects of comprehensive CAMHS provision

This chapter provides an overview of the CAMHS that were found to be in place in 2005, including the type, function and location of teams, the staffing of these teams and evidence of specialist provision to specific groups of children and young people. It includes sections on:

- 2.1 Types of CAMHS tier 2 to 4 provision**
- 2.2 Generic teams**
- 2.3 Targeted teams**
- 2.4 Dedicated worker teams**
- 2.5 Tier 4 provision**
- 2.6 On-call provision and emergency response**
- 2.7 Services for sixteen and seventeen year olds**
- 2.8 Learning disability and mental health specialisms**
- 2.9 CAMHS support for looked after children**
- 2.10 Services for young offenders**
- 2.11 Use of Information Technology**

Detailed tables of the data used can be found and downloaded from the CAMHS mapping website at:

www.camhsmapping.org.uk/2005



2.1 Types of CAMHS tier 2 to 4 provision

Child and adolescent mental health professionals provide a balance of direct and indirect services and are flexible about where children, young people and families are seen in order to improve access to high levels of CAMHS expertise.

(NSF for Children, Young People and Maternity Services 2004 – Standard 9: Markers of good practice p.5.)

Team type definitions

Generic teams: Generic CAMHS teams meet a wide range of the mental health and psychological needs of children and adolescents within a defined geographical area.

Generic (multi) teams: These are made up of CAMHS professionals from a number of disciplines who work together to ensure integrated provision.

Generic (single) teams: These are single-disciplinary groups of staff who provide a range of therapeutic interventions.

Targeted teams: These teams provide for children with particular problems or requiring particular types of therapeutic intervention.

Dedicated worker teams: Dedicated workers are fully trained CAMHS professionals who are out-posted in teams that are not specialist CAMHS teams but have a wider function, such as a youth offending team or a generic social work children's team.

Tier 4 teams: These services provide longer term or more intensive provision. This may take the form of whole- or half-day activities, inpatient care, or outreach support (such as emergency or after care) which is considered an alternative to in-patient care. Some may provide more than one of these types of care.

In total, 1,051 CAMHS teams were mapped in 2005, an increase of 6% from the 989 teams in 2004, and a 16% increase from the 905 teams mapped in 2003 (Table 2.1). There were 9,876 whole time equivalent (WTE) staff recorded in 2005, an increase of 11% on the 8892 WTE in 2004, and a 27% increase in from the 7,761 WTE staff reported in 2003.

Table 2.1: Trends in team type and staffing

Team type	Teams			Staff		
	2003	2004	2005	2003	2004	2005
Generic multi	488	433	471	4306	5072	5690
Generic single	0	59	51	0	339	310
Targeted	167	241	267	809	1060	1263
Dedicated worker	128	143	149	565	271	301
Tier 4	122	113	113	2082	2151	2312
Total	905	989	1051	7761	8892	9876

To capture the range of work undertaken, CAMHS teams were categorised into 5 types.

1. Half of the teams were generic (Fig. 2.1a). These provided the backbone of specialist CAMHS provision ensuring a range of therapeutic interventions were available to children, young people and families locally. They accounted for 62% of all CAMHS staff (Fig. 2.1b). The majority of these teams (90%) were multi-disciplinary which meant that they were staffed by a range of CAMHS professionals.

Fig. 2.1a: Types of team (N=1051)

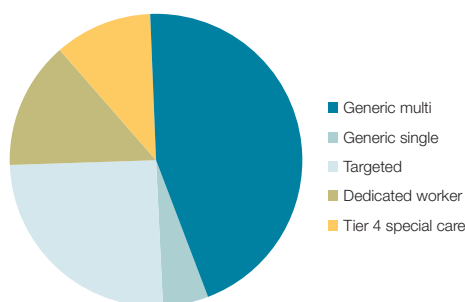
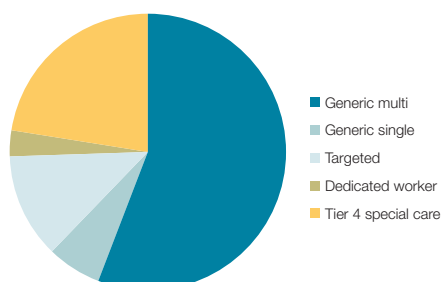


Fig. 2.1b: Staffing WTE by team type (N=9,876)



2. The remaining 10% of generic teams were staffed by a single professional group such as psychologists or social workers.
3. A quarter of teams (25%) were targeted, accounting for 12% of CAMHS staff and focusing on meeting specific needs of children and young people.
4. 14% of teams were dedicated workers. These were CAMHS professionals who provide a specialist mental health input in teams which have another related focus such as education or community paediatrics. Dedicated worker teams accounted for 3% of all CAMHS staff. This is a low proportion as only the dedicated CAMHS input was mapped in these teams, often a single CAMHS worker within a broader team.
5. 11% of teams were tier 4. These teams provided intensive support through in-patient, day care, intensive home support and intensive treatment and foster care. Needing high staffing levels, tier 4 teams employed 23% of the CAMHS workforce (Fig. 2.1b).

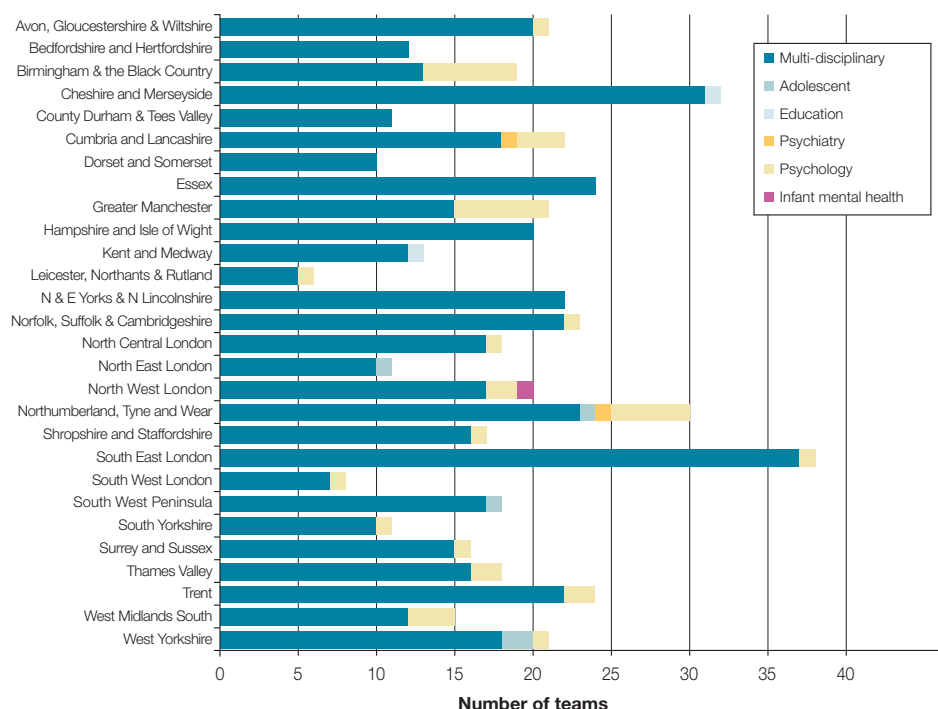
2.2 Generic teams

There were 522 generic teams mapped in 2005, this was a 6% increase on the 492 generic teams in 2004 and a 7% increase on the 488 teams in 2003 (Table 2.1).

However, the workforce in generic teams continued to rise steeply. A total of 5,999 WTE staff were reported in generic teams in 2005, an increase of 11% from the 5,410 WTE in 2004, and an overall increase of 39% on the 4,306 WTE in 2003 (Table 2.1) demonstrating considerable investment in these teams throughout the 3-year period recorded by the mapping.

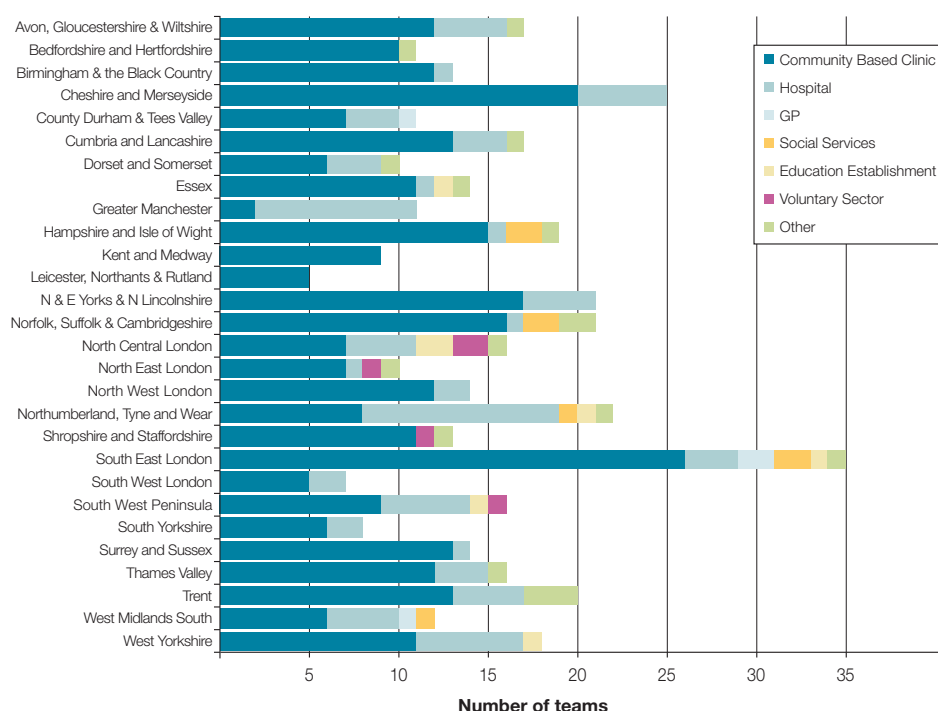
In the mapping, a distinction has been made between generic teams employing a range of CAMHS professionals and those providing a single professional focus. In 2005, 427 of all generic teams (90%) were multi-professional providing generalist CAMHS provision to a locality, an increase of 9% on the 433 multi-professional teams in 2004. The continued move to integrated CAMHS provision has been clear from the decline in single agency provision. There were just 50 single profession generic teams in 2005, a drop of 16% on the 59 teams in 2004.

Fig. 2.2a: Focus of generic teams (multi and single discipline) (N=522)



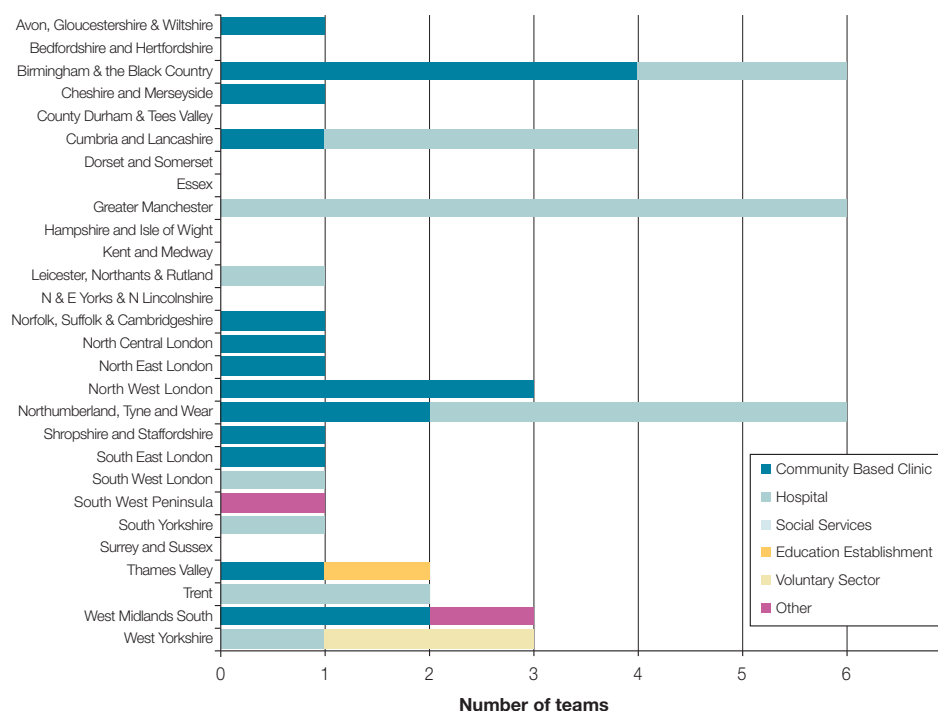
Of the generic teams that had a single discipline focus, the most common type was clinical psychology teams, accounting for 7% of all generic teams (Fig. 2.2a). The other foci of generic teams identified were psychiatry (2 teams), education (2 teams), infant mental health (1 team) and generalist adolescent provision (5 teams). In total, 3 of the adolescent teams appeared to be multi-disciplinary teams using the adolescent classification.

Fig. 2.2b: Main base of multi-disciplinary generic teams (N=471)



The majority of generic teams were located in community settings (Fig. 2.2b and c). Overall, 64% of multi-disciplinary generic teams and 39% of single disciplinary teams were community based. Hospitals were the setting for 18% of generic (multi) teams and 39% of generic (single) teams. Other settings included GP clinics, social services, education establishments and voluntary agencies. 10% of multi-disciplinary and 8% of single discipline generic teams did not report a main base.

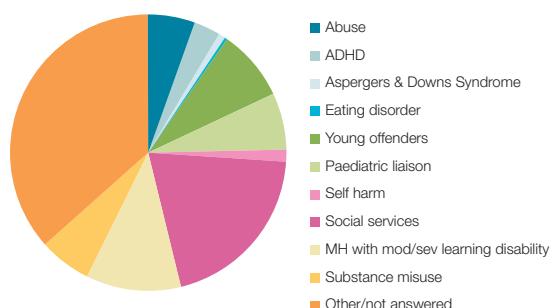
Fig. 2.2c: Main base of single discipline generic teams (N=51)



2.3 Targeted teams

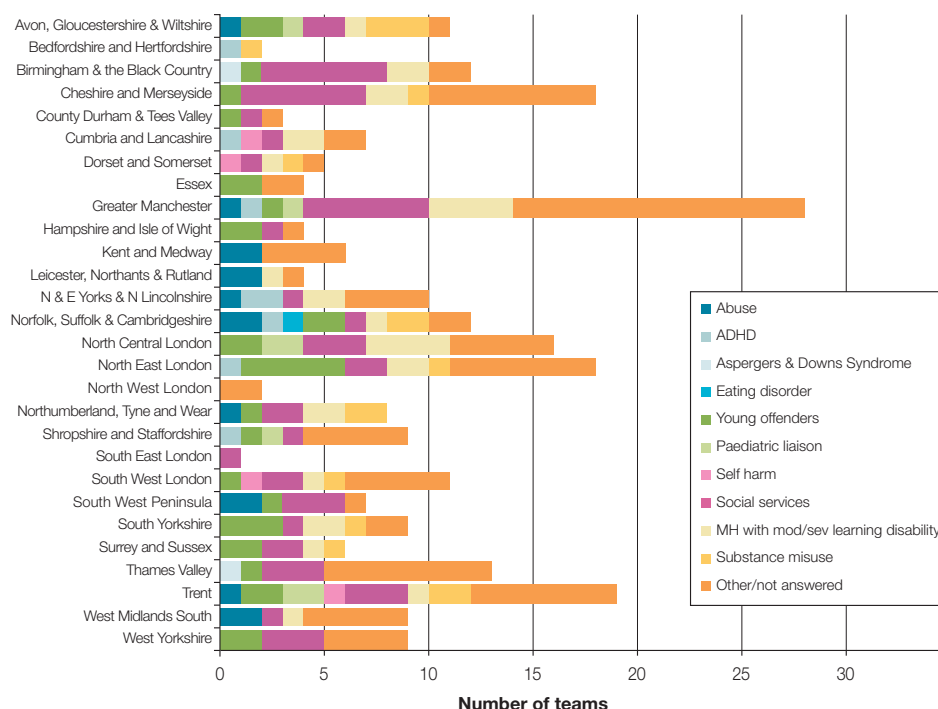
The growth of targeted teams has continued, with the number of teams increasing by 11% from 241 teams in 2004 to the 267 reported in 2005. This came on top of strong growth in 2004 when the number of teams grew from 167 in 2003 to 241 (Table 2.1). Between 2003 and 2005 there was a 60% increase in the number of targeted teams. This was mirrored by increases in the number of staff who worked in these teams, up from 809 WTE in 2003 to 1263 WTE staff in 2005, an increase of 56%.

Fig. 2.3a: Focus of targeted teams (N=267)



The most common foci for targeted teams were: looked after children in social services (53 teams); learning disabilities (30 teams); young offenders (22 teams); paediatric liaison and substance misuse teams (18 teams each). These and other foci are shown in Fig. 2.3a. Although a number of attempts have been made to reduce the number of records placed in the 'other' category, these have been unsuccessful and currently 37% of team foci lie outside the categories given.

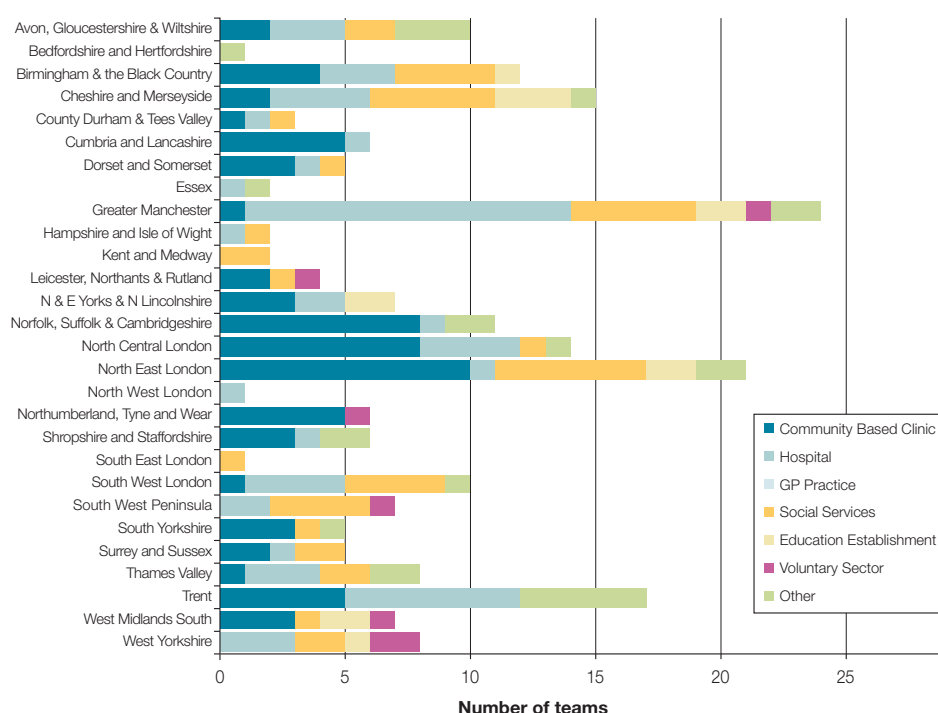
Fig. 2.3b: Focus of targeted teams by SHA (N=267)



The very scattered distribution of targeted teams can be seen in Fig. 2.3b

The location of targeted teams was influenced by the focus of the team. 66% of teams were located in community clinics, hospital or social services settings. 5% of teams were located in educational establishments and 3% in voluntary agencies. The variation in provision across the country is apparent in Fig. 2.3c. 18% of targeted teams reported no main base.

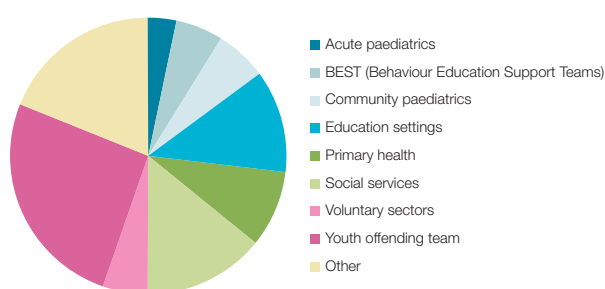
Fig. 2.3c: Location of targeted teams (N=267)



2.4 Dedicated worker teams

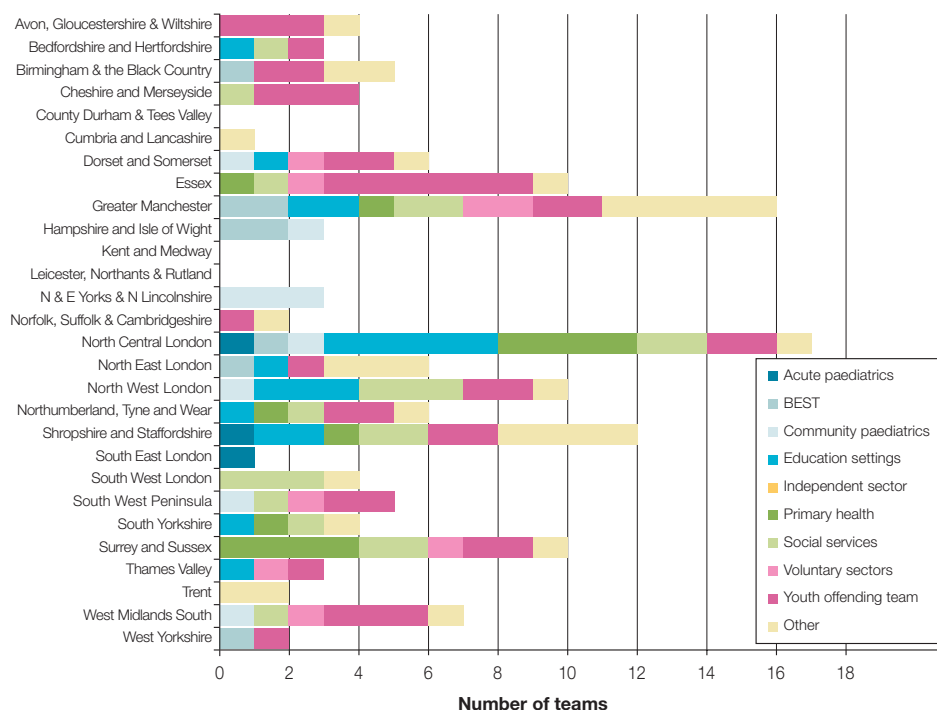
Dedicated workers were often solo CAMHS workers who worked alongside non-mental health professionals to provide a source of mental health and/or psychological expertise to ensure the delivery of integrated care. Between 2003 and 2005 there was a 16% increase in the number of non-CAMHS teams with dedicated CAMHS workers, from 128 to 149 (Table 2.1). A total of 301 WTE staff were reported within dedicated worker teams in the 2005 mapping exercise. This was an 11% increase on the number of staff reported in these teams in 2004. However, the 2003-2005 trend in dedicated CAMHS staff in non-CAMHS teams shows a decrease in staffing owing to inconsistencies in the way non-CAMHS teams were mapped in the first two years of mapping (Table 2.1). The mean number of dedicated CAMHS workers in a non-CAMHS team was 2.0 WTE in 2005 and 1.9 WTE in 2004.

Fig. 2.4a: Focus of dedicated worker teams (N=149)



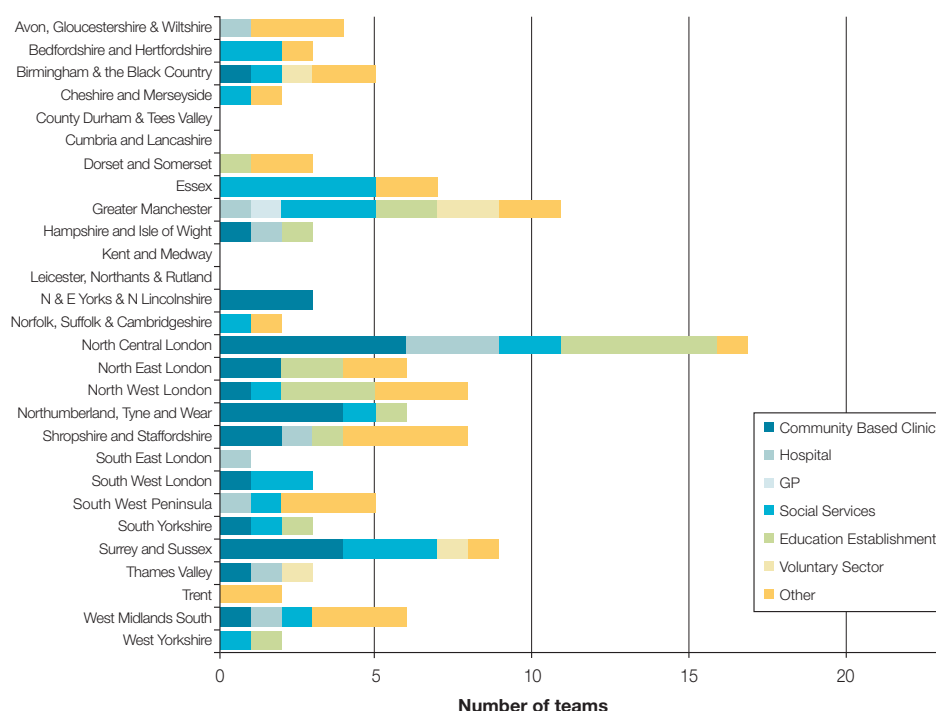
The focus of dedicated worker teams remained similar to previous years, with an emphasis on youth offending teams (26% of teams), social services (14%), and teams in educational settings (12%) (Fig. 2.4a). However, a wide range of different types of setting were apparent with very varied provision around the country (Fig. 2.4b).

Fig. 2.4b: Focus of dedicated worker teams (N=149)



The majority of dedicated worker teams were community based. 19% of teams had a main base in community clinics, 17% in social services settings and 12% in educational establishments (Fig. 2.4c). Only 7% had a main base in a hospital setting. 22% were recorded in 'other' settings while 18% of dedicated worker teams had no main base.

Fig. 2.4c: Main base of dedicated worker teams (N=149)



2.5 Tier 4 provision

The number of tier 4 teams fell by one between 2004 and 2005, to 113 (Table 2.1). However, the staffing and capacity of these teams had increased, indicating that the change was due to service restructuring. Staffing increased by 6%, from 2,176 WTE in 2004 to 2,312 WTE in 2005, and increased by 11% from the 2,082 WTE reported in 2003. Please note, the mapping does not capture data on independent sector provision.

The number of commissioned beds increased by 4%, from 651 reported in 2003 to 665 in 2004 and to 680 in 2005 (Table 2.5a). The number of available inpatient beds increased by 9%, from 569 in 2004 to 621 in 2005¹. There was a 5% increase in the number of day places from 457 in 2004 to 478 in 2005, and a 73% increase from 2003, where 277 day places were reported. The number of intensive home support places increased by 2%, between 734 in 2004 to 747 in 2005. However, there was a 5% fall in the number of places from 788 reported in 2003 (see Table 2.5a). The number of foster care placements continued to increase, from 15 in 2003, to 51 in 2004 and 64 in 2005².

¹ No data on available inpatient beds was collected in 2003.

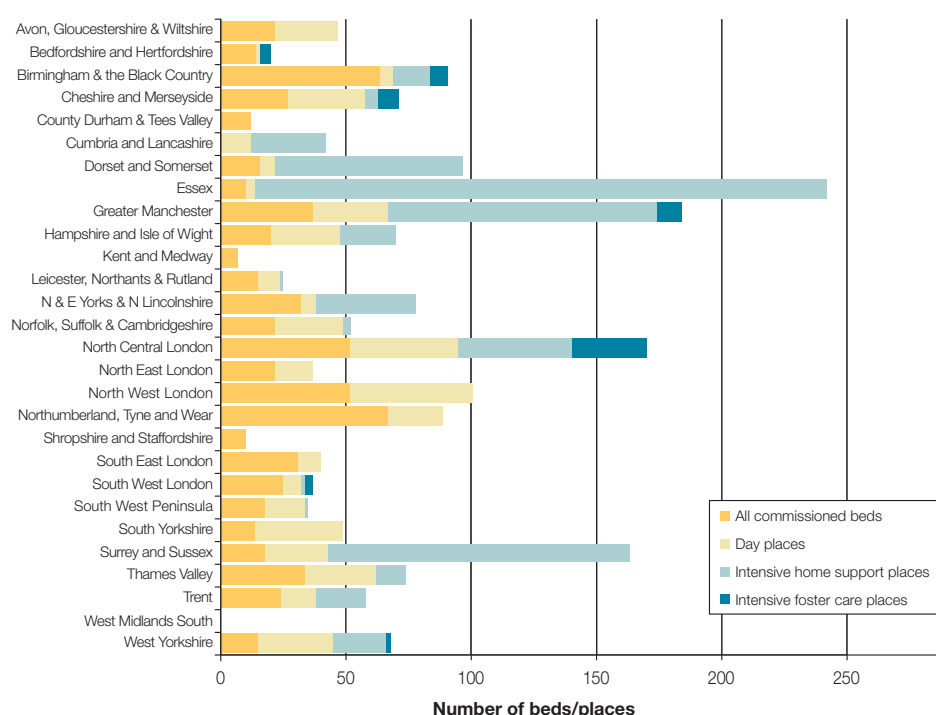
² A Tier 4 report will be published on the mapping website by the autumn of 2006, exploring in more detail provision to local geography.

Table 2.5a: Trends in Tier 4 provision 2003 and 2005

	2003	2004	2005
Day places	227	457	478
Commissioned beds	651	665	680
Available beds		569	621
Intensive home support	788	734	747
Foster care	15	51	64

Table 2.5b shows some concentration of tier 4 provision in trusts that provide national and regional services but overall there was a reasonable distribution of inpatient beds throughout the country. The provision of intensive day care places remains patchy and foster care places were limited to a small number of locations (Fig. 2.5a).

Fig. 2.5a: Capacity of Tier 4 provision by SHA

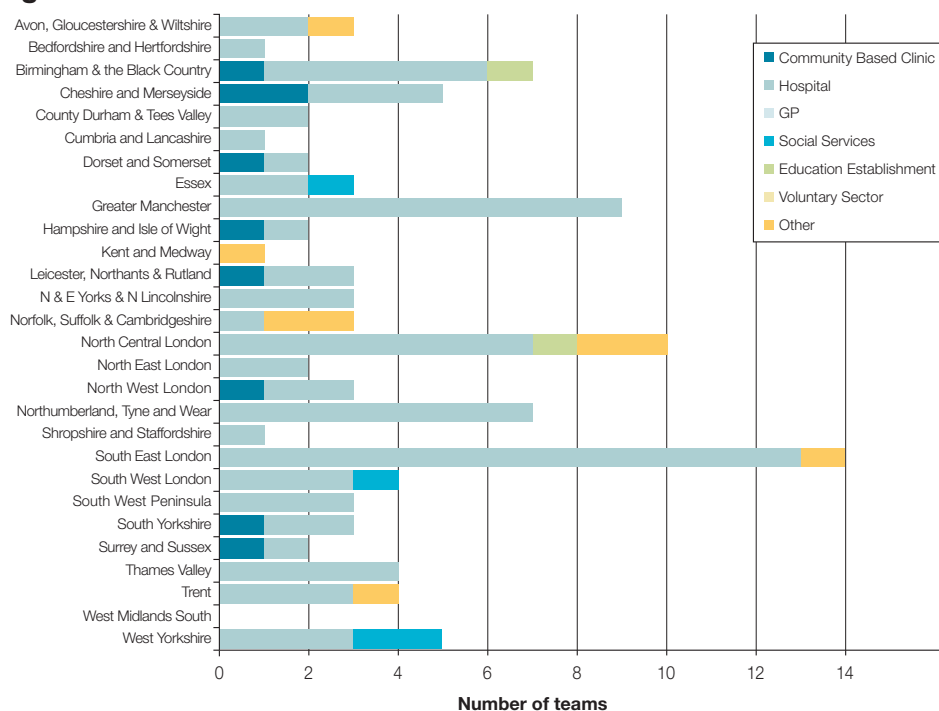


A small number of tier 4 teams (5%) were identified as having no main base. Of the remaining teams, the majority were in a hospital setting (74%) reflecting the dominance of inpatient services (Fig. 2.5b). Just 8% of teams were in a community setting, 4% within social services and 2% within educational establishments. 7% of tier 4 teams had an 'other' location.

Table 2.5b: Tier 4 team capacity, 2005

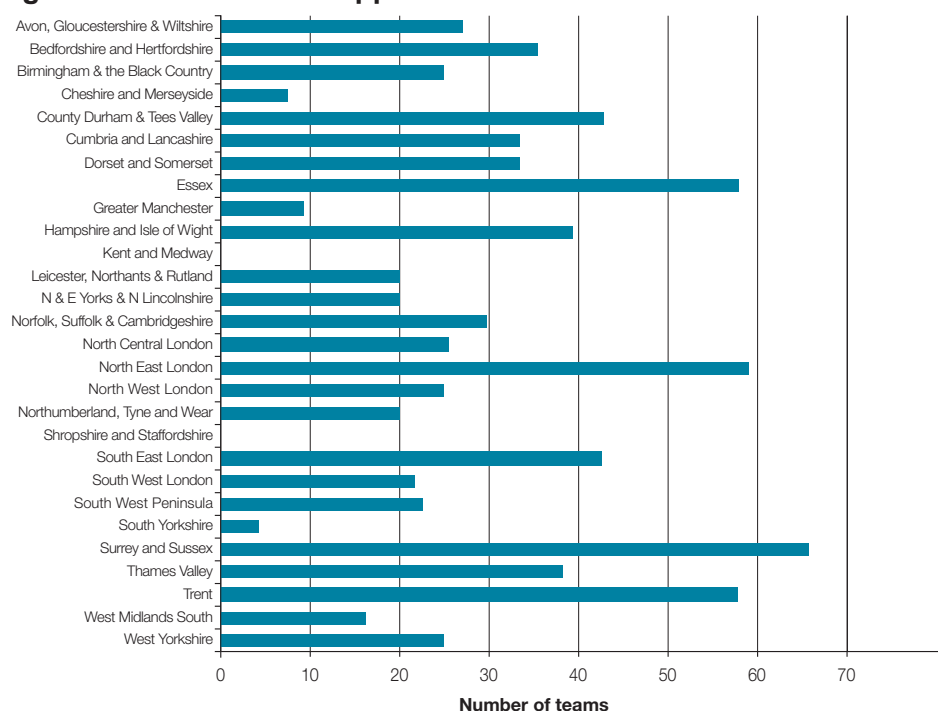
2005	No. Tier 4 Special Care Teams	Teams with inpatient beds currently in use	Inpatients units	Inpatients units with commissioned beds	All commissioned beds	Teams with day places	Day places	Teams with intensive home support	Intensive home support places	Teams with intensive foster care	Intensive foster care places
Avon, Gloucestershire & Wiltshire	3	2	19	2	22	3	25	-	-	-	-
Bedfordshire and Hertfordshire	1	1	14	1	14	1	2	-	-	1	4
Birmingham & the Black Country	7	5	52	5	64	1	5	1	15	2	7
Cheshire and Merseyside	5	3	19	3	27	2	31	2	5	1	8
County Durham & Tees Valley	2	2	22	1	12	-	-	-	-	-	-
Cumbria and Lancashire	1	-	-	-	-	1	12	1	30	-	-
Dorset and Somerset	2	2	13	2	16	1	6	1	75	-	-
Essex	4	1	10	1	10	2	4	2	228	-	-
Greater Manchester	9	3	37	3	37	5	30	4	107	1	10
Hampshire and Isle of Wight	2	1	20	1	20	2	28	1	22	-	-
Kent and Medway	2	2	28	1	7	-	-	-	-	-	-
Leicester, Northants & Rutland	3	2	15	2	15	2	9	1	1	-	-
Norfolk, Suffolk & Cambridgeshire	3	2	11	3	32	3	6	1	40	-	-
N & E Yorkshire & N Lincolnshire	3	3	22	3	22	3	27	1	3	-	-
North Central London	11	3	13	4	52	5	43	4	45	2	30
North East London	2	2	24	2	22	2	15	-	-	-	-
North West London	3	2	49	2	52	3	49	-	-	-	-
Northumberland, Tyne and Wear	7	6	70	6	67	2	22	-	-	-	-
Shropshire and Staffordshire	1	1	10	1	10	-	-	-	-	-	-
South East London	16	4	39	4	31	3	9	-	-	-	-
South West London	4	3	23	3	25	2	7	1	2	1	3
South West Peninsula	3	2	18	2	18	2	16	1	1	-	-
South Yorkshire	3	2	2	2	14	3	35	-	-	-	-
Surrey and Sussex	2	1	18	1	18	2	25	2	120	-	-
Thames Valley	5	3	34	3	34	4	28	1	12	-	-
Trent	4	2	24	2	24	2	14	1	20	-	-
West Midlands South	-	-	-	-	-	-	-	-	-	-	-
West Yorkshire	5	3	15	3	15	3	30	2	21	1	2
Total	113	63	621	63	680	59	478	27	747	9	64

Fig. 2.5b: Tier 4 team location of main base



A new question was added to the questions asked of tier 2/3 teams in 2005 to collect information on the support they provided to tier 4 teams and cases. Of the 938 tier 2/3 teams, 267 (28%) provided support to tier 4. The proportion of teams in each SHA area that reported that they provided support to tier 4 varied from 0 in two SHAs to 66% (Fig. 2.5b). It will be interesting to examine trends in this provision in future mapping exercises and it is expected that accuracy of the data will improve.

Fig. 2.5c: Tier 2/3 team support to Tier 4



2.6 On-call provision and emergency response

Children and young people presenting as emergencies or as requiring urgent assessment and intervention include: those who have rapidly developed a serious or life-threatening condition; those whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support.

(NSF for Children, Young People and Maternity Services 2004 – Standard 9, p.18.)

From the outset, CAMHS mapping has sought to identify which services provide on-call cover that is available 24 hours a day, 7 days a week and are able to respond to the mental health needs of children and young people in an emergency and/or a mental health assessment within 24 hours or by the end of the next working day. A range of provision was found and although progress in the development of provision had been disappointing, in 2005 almost full national coverage was found.

- Overall 88 services (64%) had an on-call service, 61 of which (44% of all services) had on-call provision that provided a response by CAMHS professionals (Table 2.6).
- This was an increase of 10 on-call services since 2004. The number of services with a specialist 24/7 response declined by one owing to a merger of two services since 2004 (see Fig. 1.3d).
- This meant that 50 services (36%) had no 24/7 on-call.
- Of the services without an on-call service, 43 provided next day emergency response by CAMHS professionals³. This left only 7 CAMHS with no specific CAMHS emergency response, a reduction from 19 services in 2004. It is important to note that these 7 services are predominantly specialist tier 4 services which would not be expected to provide local emergency services.

³ If a service provides an on-call service they are not asked whether they provide a next day response. However, 15 services with on-call indicated that they also provided a next day response, these services are excluded from this analysis.

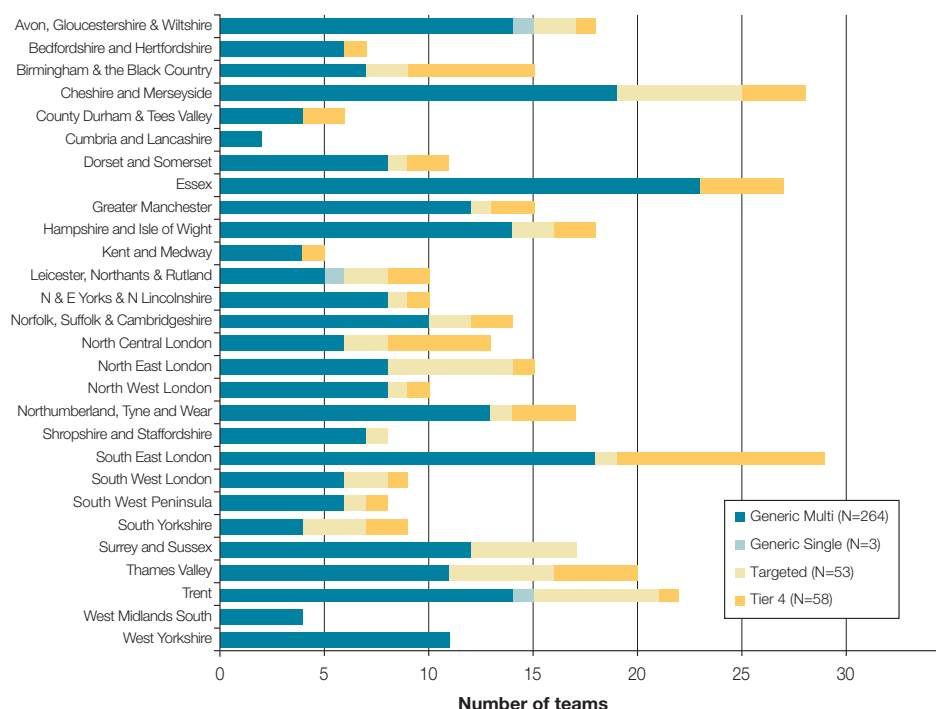
Table 2.6: On-call and emergency provision

SHA	Number of Services	Provides On-call	Provides Exclusive CAMHS On-call	Next Working Day Appointment
Avon, Gloucestershire & Wiltshire	7	6	3	1
Bedfordshire and Hertfordshire	2	1	1	1
Birmingham & the Black Country	7	4	1	2
Cheshire and Merseyside	7	2	2	5
County Durham & Tees Valley	2	1	1	1
Cumbria and Lancashire	9	-	-	7
Dorset and Somerset	3	2	1	1
Essex	2	2	1	0
Greater Manchester	9	6	6	2
Hampshire and Isle of Wight	8	7	5	1
Kent and Medway	2	1	1	1
Leicester, Northants & Rutland	3	2	1	1
Norfolk, Suffolk & Cambridgeshire	8	2	2	6
N & E Yorkshire & N Lincolnshire	5	4	4	1
North Central London	10	10	7	-
North East London	2	2	2	-
North West London	4	3	1	-
Northumberland, Tyne and Wear	6	4	2	2
Shropshire and Staffordshire	3	3	1	-
South East London	3	3	1	-
South West London	1	1	-	-
South West Peninsula	4	2	1	1
South Yorkshire	5	3	1	2
Surrey and Sussex	5	4	4	1
Thames Valley	7	5	5	1
Trent	5	3	3	2
West Midlands South	5	3	3	2
West Yorkshire	4	2	1	2
Total	138	88/138	61/88	43/50

Enquiries about the teams that provided the on-call response showed that a total of 378 (42%) CAMHS teams contributed⁴. Of the teams with an on-call response, 264 (70%) were generic multi-disciplinary teams, 58 (15%) were tier 4 teams and 53 (14%) were targeted teams (Fig. 2.6). It was interesting to note that 51% of all tier 4 teams contribute to an on-call service.

Local authorities were asked about the arrangements they had in place to ensure that 24 hour cover was available to meet the urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated. 55 (37%) local authorities were found to have fully implemented 24/7 on-call services, 70 (47%) had plans, protocols and partially implemented services and 16 (11%) had plans and protocols, but no services in place. 5 local authorities (3%) were yet to address the need for 24/7 cover in their strategic plans.(see Figure 1.3i)

Fig. 2.6: Teams with an on-call response N=378



⁴ Not asked of dedicated workers in non-CAMHS teams (N.=149).

2.7 Services for people of sixteen and seventeen years of age

A degree of flexibility is clearly required to ensure that young people receive treatment in an environment that promotes their engagement and responds to their developmental needs. This means that some young people may wish to exercise choice about which services feel most appropriate to them.

(NSF for Children, Young People and Maternity Services 2004 – Standard 9. p.21.)

A new question was added to CAMHS mapping in 2005 on provision of services for 16 and 17 year olds in response to national concerns about the adequacy of services to meet the particular mental health needs of young people of this age in transition between children and adult services. Attention has been drawn to this issue in the CNSF and it has since become the subject of a national target for health and social care. There is no prescription of the services to be provided but key elements should be in place including:

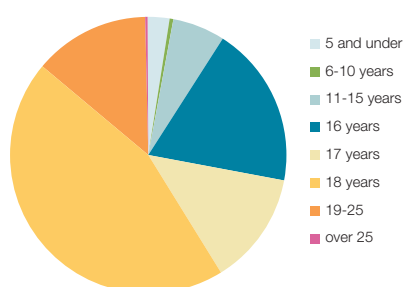
- Services appropriate for the developmental needs of 16 and 17 year olds
- Local arrangements for handling referrals
- Smooth transition between CAMHS and adult services at the appropriate age
- Collaboration with early intervention teams for young people with early onset psychosis
- The use of the Care Programme Approach for young people leaving inpatient care
- Appropriate attention to child protection needs of young people.

Responses to the question in the mapping were provided by 118 of the 138 services participating in the exercise, a response rate of 86%. Of these responding, 66 (56%) reported making specialist provision for 16/17 year olds.

In addition to asking about service wide arrangements for specialist 16/17 provision, each team was asked whether it provided a service appropriate for the level of maturity of young people of this age. A total of 338 (32%) CAMHS teams reported this provision despite a total of 755 (72%) teams recording a maximum age limit of 17 or above. 137 teams (13%) had an upper age limit of 17, 472 (45%) had an upper age limit of 18 and 146 (14%) had an upper age limit of 19 or above (Fig. 2.7a).

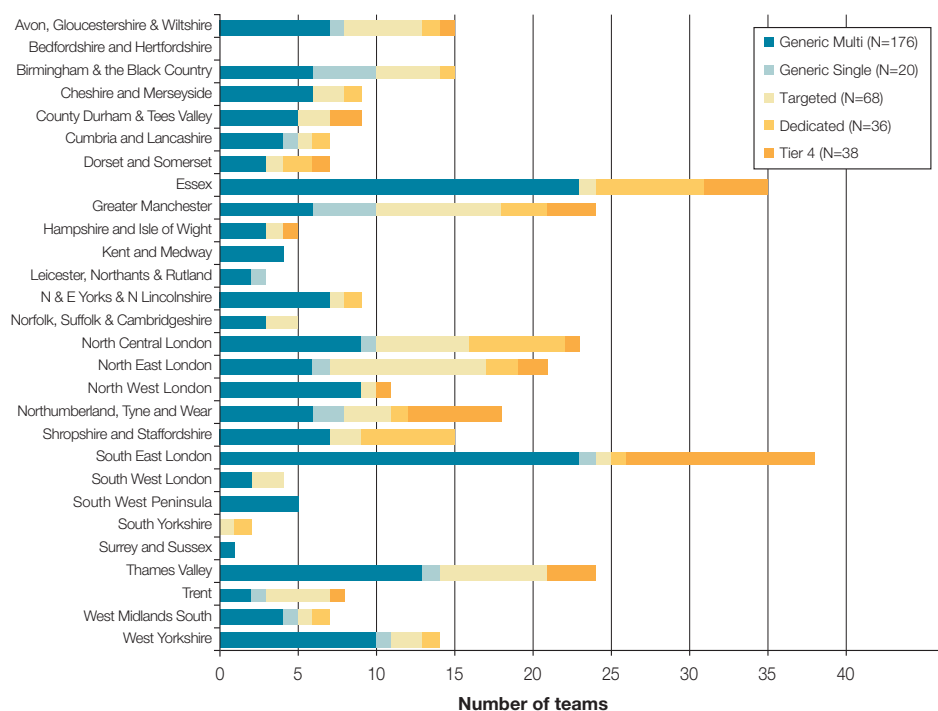
Of the 338 teams providing specialist services for 16/17 year olds, 176 (52%) were multi-disciplinary generic teams, 20 (6%) were single discipline generic teams, 68 (20%) were targeted teams, 36 (11%) were dedicated worker teams, and 38 (11%) were tier 4 teams (Fig. 2.7b).

Fig. 2.7a: Upper age limit of team provision (N=1051)

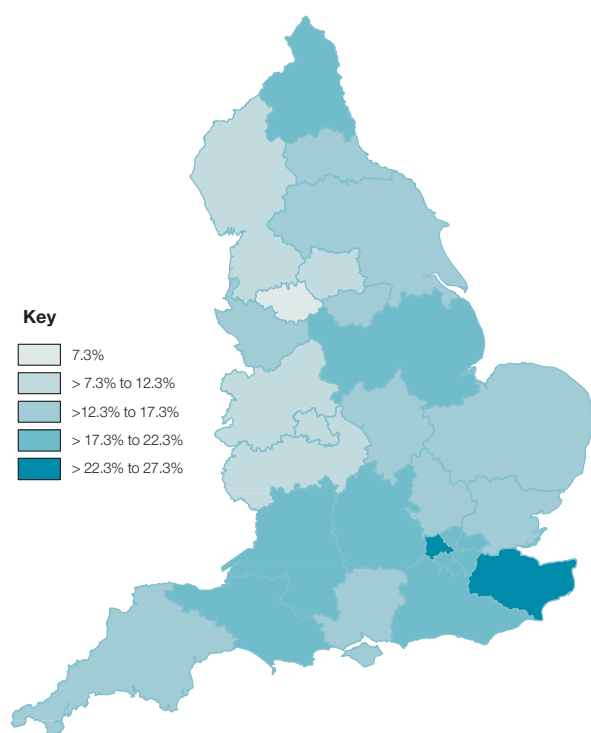


Local authorities were also asked about the provision of services to 16 and 17 year olds who require mental health services appropriate to their age and level of maturity within the council area. 25 (17%) local authorities had fully comprehensive CAMHS for 16 and 17 year olds across the whole council area, 91 (61%) had plans, protocols and some services and 27 (18%) had plans and protocols but no services. Three local authorities (2%) reported having nothing in place. See also Fig 1.3h.

Fig. 2.7b: Teams with specialist 16/17 service N=338



Map 2.7: Proportion of caseload age 16 or over



Overall, there were 17,577 cases aged 16 or above in 2005, 16% of the total caseload (Map 2.7). This was an increase on the previous year when 12,913 cases (14%) had been aged 16 or above (see section 4.5 below). Higher numbers of cases aged 16 and over were found in both tier 2/3 teams and tier 4 provision. In tier 2/3 teams, 16,101 cases, 15% of the caseload was aged 16 or above, this was an increase on the 11,679 cases aged 16 or above in 2004, which accounted for 13% of the total caseload. In tier 4 teams the proportion of older adolescents was greater at 29%, this has also increased from the 26% share reported in 2004.

2.8 Learning disability and mental health specialisms

There is a need to ensure that children and young people with learning disability who require psychiatric care have access to appropriate services that meet their needs and that they are not disadvantaged because of their disability.

(NSF for Children, Young People and Maternity Services 2004 – Standard 9. p.23.)

The CNSF stresses the importance of equity of access to CAMHS for children and young people with both mental health needs and learning disabilities. Adequate provision would be expected to include:

- Adequate provision of mental health promotion and early intervention
- Specialist staff training for both tier 2/3 and tier 4 staff
- Adequately resourced tiers 2 and 3 learning disability specialist CAMHS
- Access to tier 4 services providing in-patient, day-patient and outreach units.

In the 2005 CAMHS mapping, strong growth was found in the number of services providing specialist provision for children and young people with both learning disabilities and mental health problems. The number of services had risen from 48 in 2003, to 62 in 2004 and 68 in 2005 with reasonable spread around the country (Map 2.8 and Fig. 2.8a). However, care should be taken in interpreting this data, as small service providers may have no specific learning disability provision because a service is provided by a neighbouring trust through a partnership arrangement.

Map 2.8: Proportion of services with specialist mental health and learning disability problems

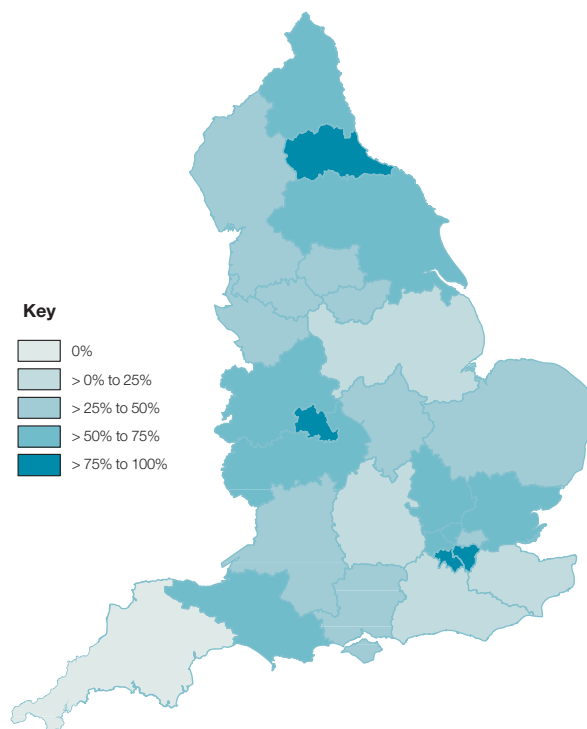
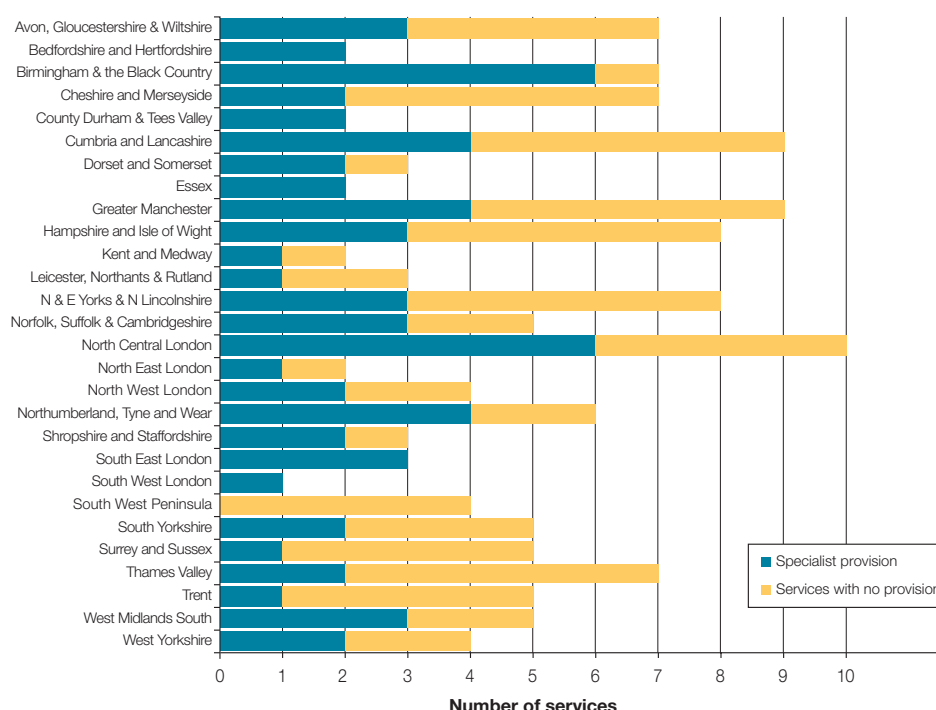


Fig. 2.8a: Learning disability and mental health provision by registered service (N=138)



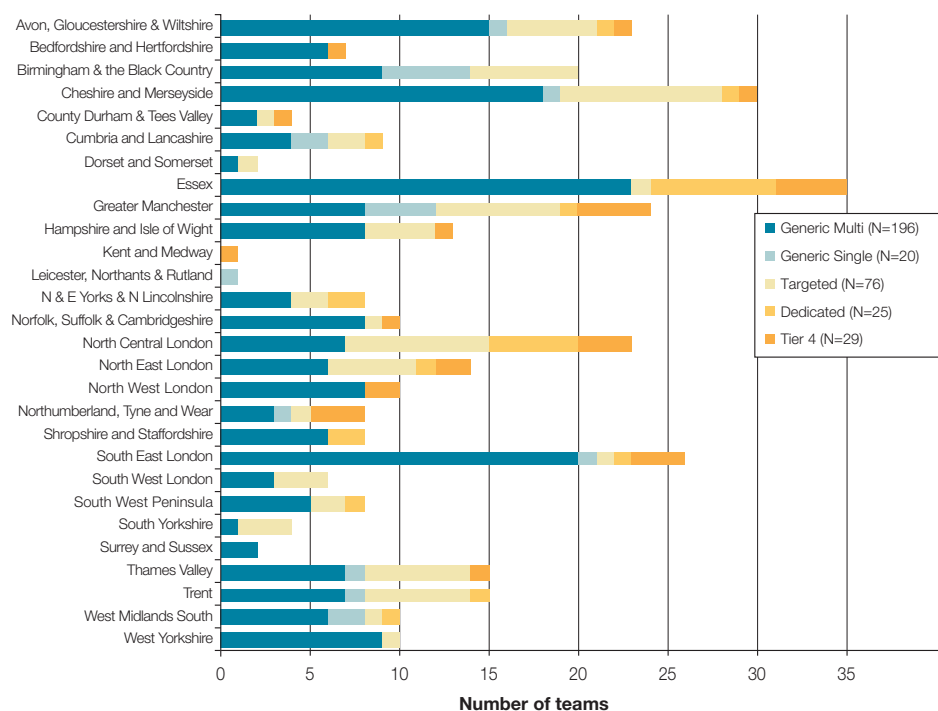
To find out where this specialist support was provided, every team was asked to indicate if they offered a specialist service for children and adolescents with mental health problems who also have a learning disability. Overall, 346 (33%) teams reported provision. In terms of the type of team providing a specialist learning disability service, 196 were multi-disciplinary generic teams (57% of the specialist learning disability teams), 20 (6%) were single discipline generic teams, 76 (22%) were targeted teams, 25 (7%) were dedicated worker teams, and 29 (8%) were tier 4 teams (Fig. 2.8b).

An examination of team caseload revealed that the majority of children with learning disabilities were supported by generic teams and a very small number of tier 4 team caseloads reported having a significant number of cases with a learning disability. Of the learning disability cases the following was found:

- 5428 cases in generic multi-disciplinary teams (57% of learning disability cases)
- 801 cases in single professional generic teams (8% of learning disability cases)
- 2136 cases in targeted teams (22% of learning disability cases)
- 647 cases in dedicated worker teams (7% of learning disability cases)
- 526 cases in tier 4 teams (6% of learning disability cases).

Only 4 local authorities (3%) were able to report provision of a fully comprehensive CAMHS for children with learning disabilities and mental health needs covering the whole council area but 96 local authorities (64%) had plans and protocols and some services in place, but services still needed to be developed to cover the whole council area. 33 local authorities (22%) had plans and protocols in place, but no services. 13 local authorities (9%) had no CAMHS provision in place for children and young people with learning disabilities (Fig. 1.3g).

Fig. 2.8b: Teams with specialist learning disability provision N=346



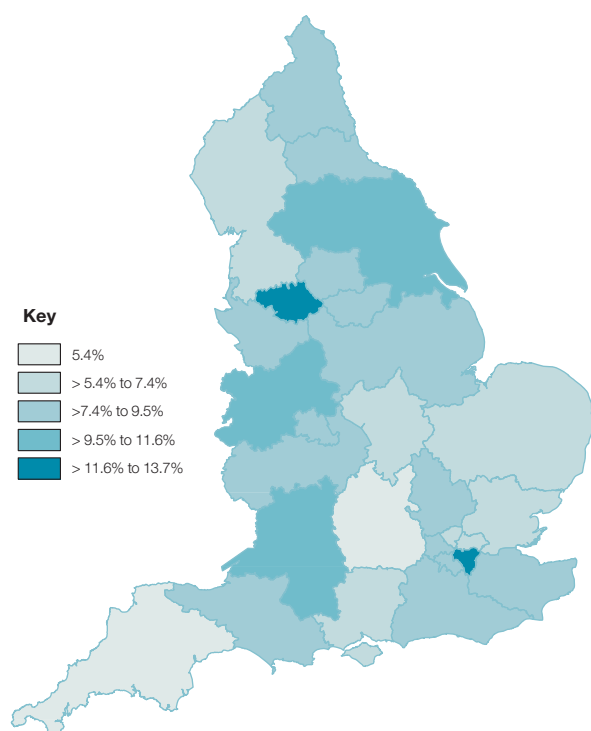
2.9 CAMHS support for looked after children

Looked after children are five times more likely than their peers to have a mental health disorder.

(NSF for Children, Young People and Maternity Services 2004 – Standard 9. p.7.)

There were 9745 cases (9% of the total 2005 caseload) identified as looked after children in the 2005 mapping, an increase of 15% on the 8,448 cases (8% of the total 2004 caseload) identified in 2004. Provision for this group varied around the country with the proportion of the caseload varying from 5.4% to 13.7% (Map 2.9).

Map 2.9: Looked after children as proportion of caseload (2005)



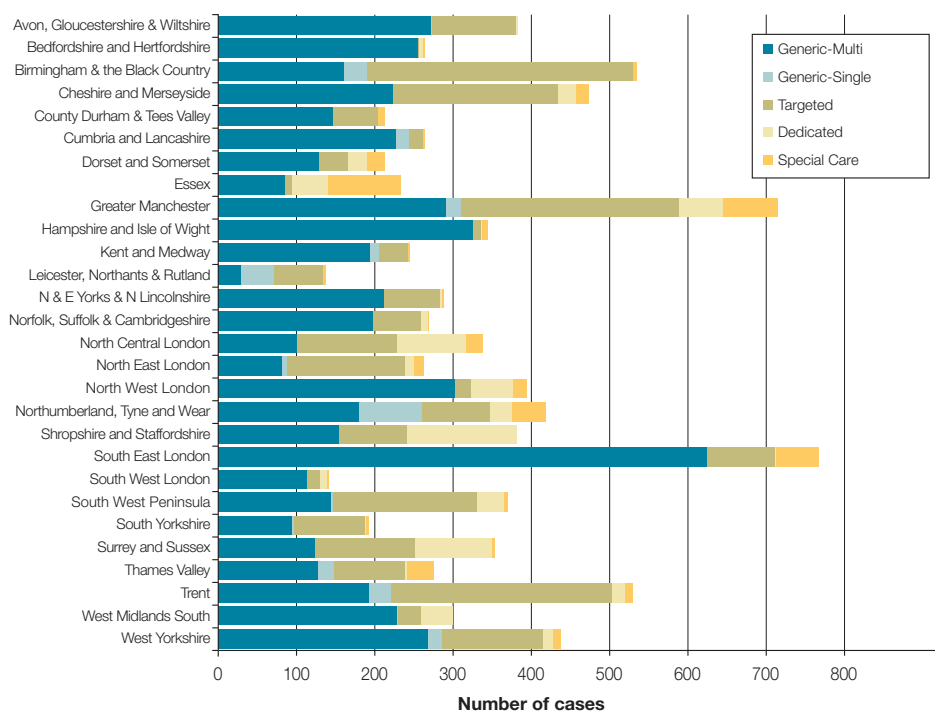
DfES statistics show that there were 60,900 looked after children in England as at 31.3.05, with 10,800 of these children over 16 years of age⁵. This means that 1 in every 6.2 looked after child was seen by CAMHS in the sample period in 2005. The comparative figure for 2002 was 1 looked after child seen by CAMHS for every 8.6 in England, showing that the proportion of looked after children being seen by CAMHS is increasing.

56% of looked after children (5,484) received care from multi-professional generic teams, 29% (2,802) from targeted teams, 7% (712) from dedicated worker teams, 5% (452) from tier 4 teams and 3% (295) from generic single discipline teams. However, this varied across SHA area (Fig. 2.9).

Looked after children made up the majority of the caseload of targeted and dedicated worker teams with a social services focus, therefore trends in these teams were an indication of changes in provision for looked after children. 75% of the caseload of the social services targeted teams were looked after children, an increase from 72% in 2004. In dedicated worker teams the increase was more marked, rising from 45% of caseload in 2004 to 66% in 2005. Overall, 74 teams had a social services focus in 2005, an increase of 12 teams on the 62 mapped in 2004. 53 of these were targeted teams and 21 were dedicated worker teams.

⁵ From DfES, *Children Looked After in England (including adoptions and care leavers)*, 2004-05. <http://www.dfes.gov.uk/rsgateway/DB/SFR/s000615/SFR51-2005.pdf>

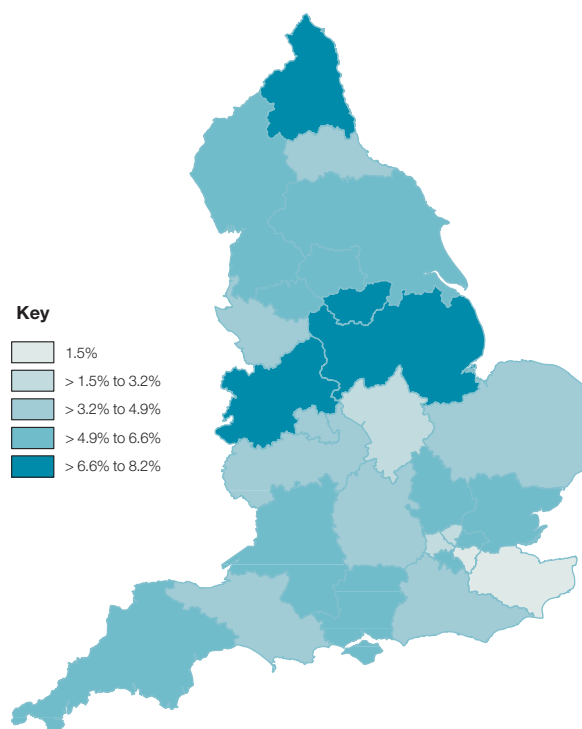
Fig. 2.9: Looked after children by team type (N=9,745)



2.10 Services for young offenders

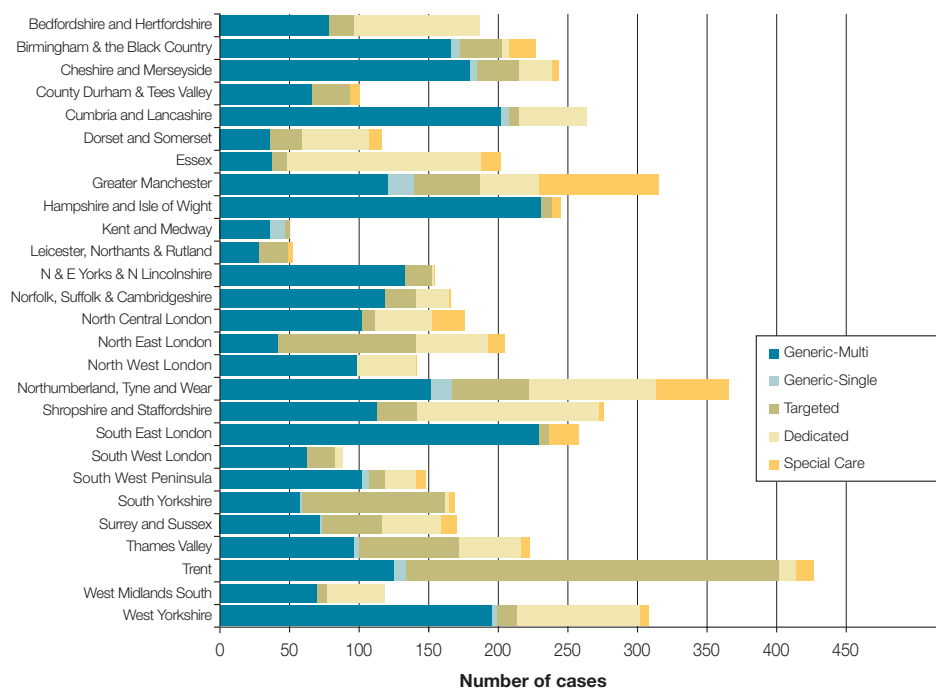
- Overall there was an increase of 9% in the number of teams specifically targeting support for young offenders (Fig. 1.3e). These included 22 targeted teams and 38 dedicated CAMHS workers working in non-CAMHS teams. This reversed the trend observed the previous year.

Map 2.10: Proportion of caseload who were young offenders



- 5,645 young offenders received care from CAMHS, 5% of the total caseload. Fig. 2.10 highlights variations across the country in the types of team that have young offenders on their caseload.
- The proportion of young offenders within the total CAMHS caseload varied between 1.5% to 8.2% across the SHAs (Map 2.10).

Fig. 2.10: Young offenders by team type (N=5,645)



2.11 Staff use of information technology

Figs. 2.11a-f show staff access to, and use of, different IT systems. There have been small increases in the use of these different systems. 64% of staff used emails in 2005, compared with 63% in 2004. 63% of staff used the internet in 2005, compared with 61% in 2004. 52% of staff used NHS Net in 2005, compared with 51% in 2004. 19% of staff used electronic clinical notes in 2005, compared with 14% in 2004. 30% of staff used electronic clinical information in 2005, compared with 31% in 2004. 42% of staff accessed and used activity statistics in 2005, compared with 35% in 2004.

Fig. 2.11a: Staff access to and use of email

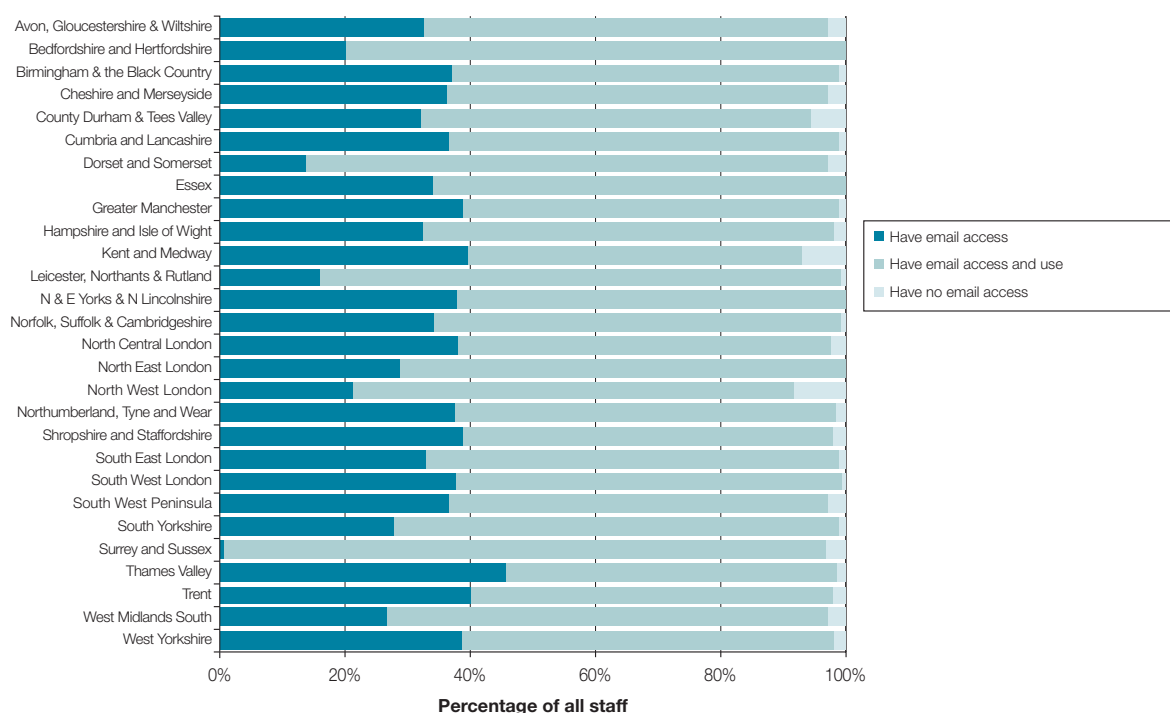


Fig. 2.11b: Staff access to and use of internet

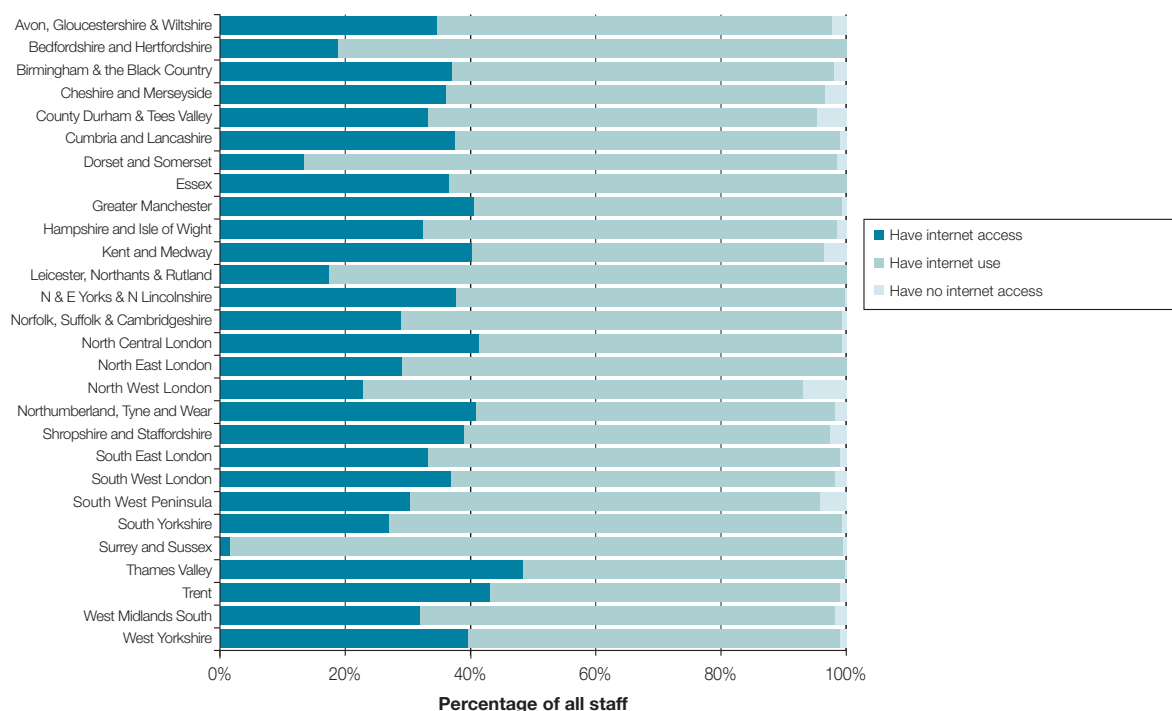


Fig. 2.11c: Staff access to and use of NHS Net

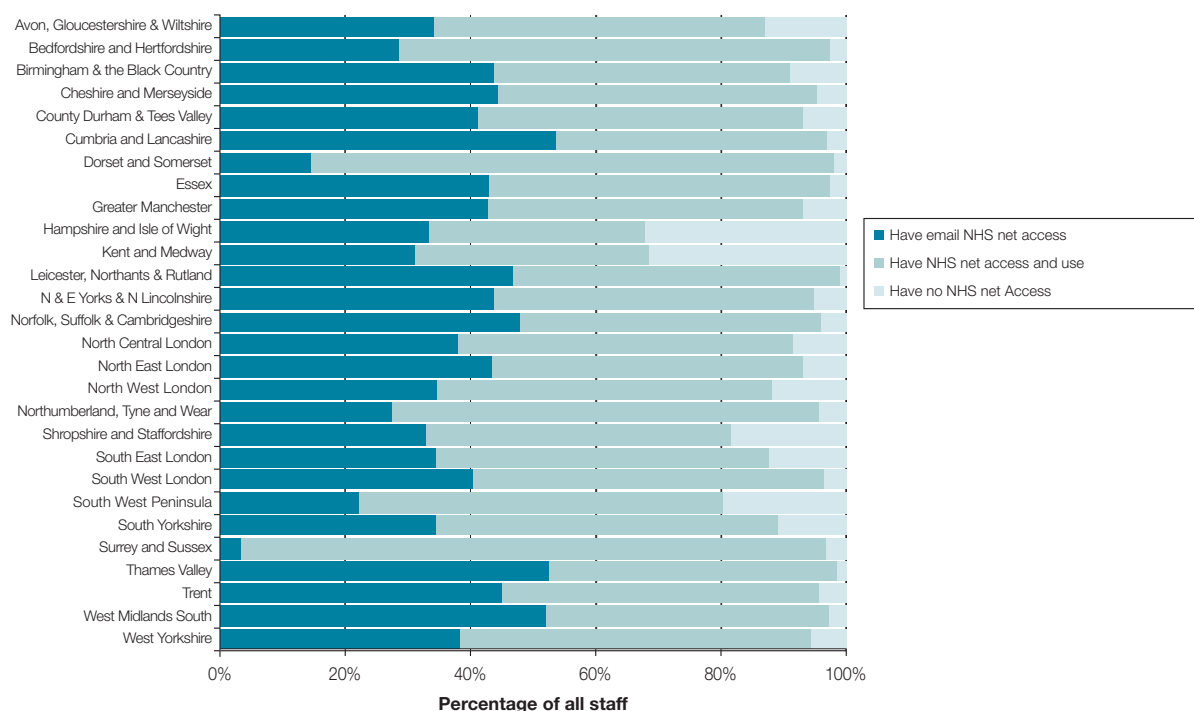


Fig. 2.11d: Staff access to and use of electronic clinical notes

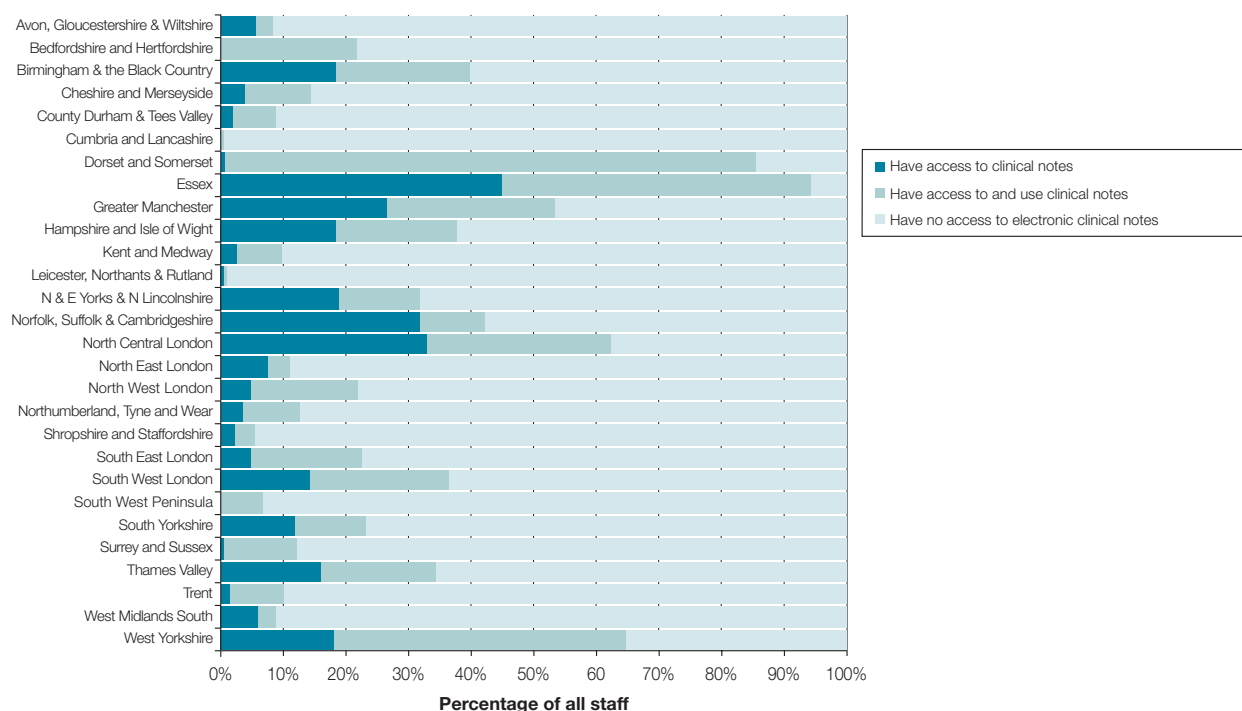


Fig. 2.11e: Staff access to and use of electronic clinical information

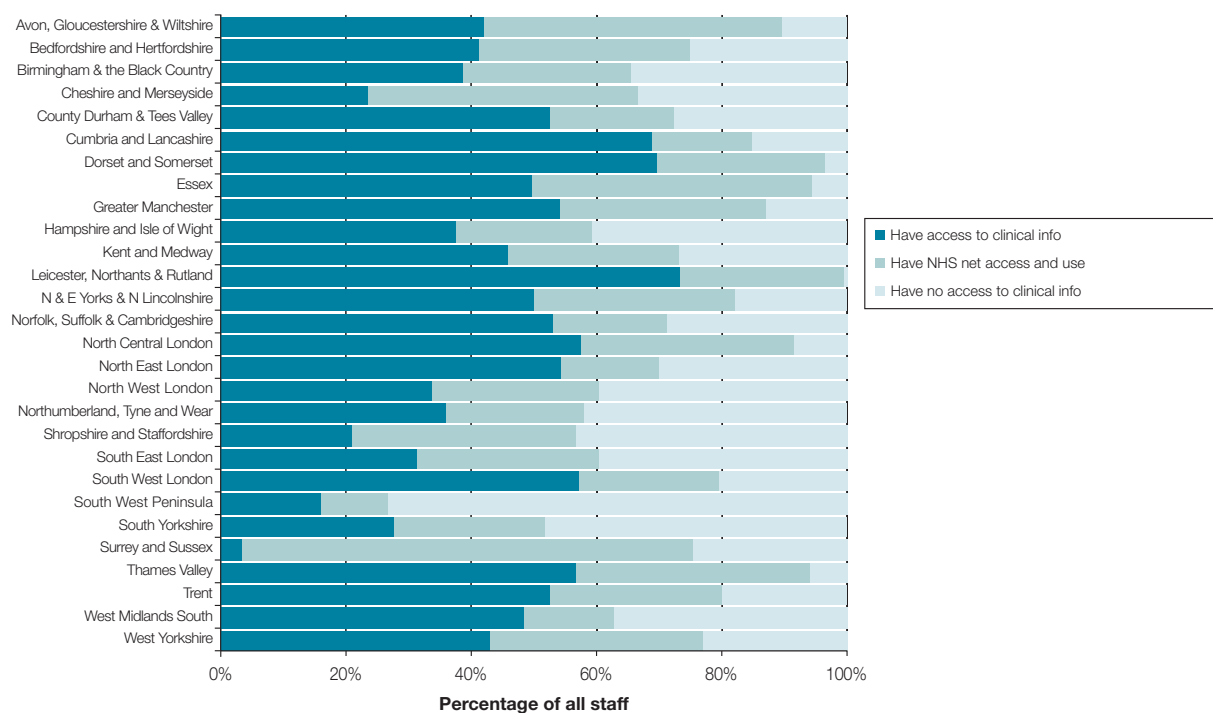
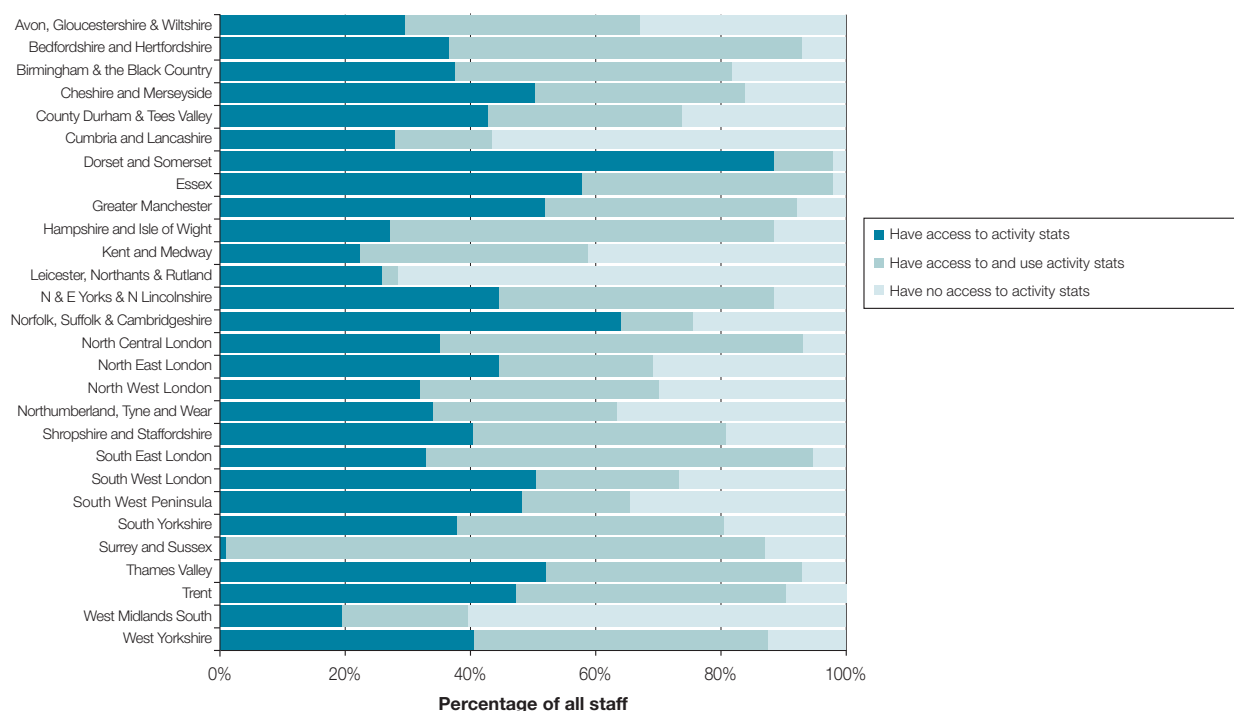


Fig. 2.11f: Staff access to and use of activity statistics



Chapter 3:

Investment

This chapter reports the findings of the CAMHS finance mapping that was completed by both PCT and local authority commissioners in 2005/6. This was the second year that PCT commissioners had submitted data directly on the mapping website and the first year that local authorities were asked to complete a separate submission. Local authority data was required by the Commission for Social Care Inspection (CSCI) and this requirement was beneficial in increasing the engagement of LAs in the mapping generally and in the finance mapping in particular.

A key finding of the mapping is the change in investment in CAMHS tier 2 to 4 services. It should be noted that in each mapping exercise data is collected for two financial years. These are the actual spend in the previous financial year and the predicted budget for the current year. The data was asked for both financial years so that the calculations for both years will be based on the same assumptions, comparing like with like. Therefore, in this section, comparisons are made between the actual budget for 2004/5 and the predicted budget for 2005/6 – the data was provided in early 2006 before the end of the financial year.

The chapter presents the following sections:

3.1 Total CAMHS budget and budget change

3.2 Source of funding

3.3 Spend per child

3.4 Provider share of funding

Note on accuracy

As the finance mapping is complex, requiring identification of investment in CAMHS tier 2 to 4 services by commissioner and providing agency, it is very difficult to confirm the accuracy of the data submitted. Details of the data checks made by the Durham Mapping Team are described in Chapter 6 but localities also continue to check the data submitted and may request changes to be made. Hence, reductions had been made to the 2004 data following publication of last year's atlas.

Detailed tables of the data used can be found and downloaded from the CAMHS mapping website at:

www.camhsmapping.org.uk/2005/reports

Group commissioning data are not available on the website but individual PCT and LA summary reports can be found at:

www.camhsmapping.org.uk/2005



3.1 CAMHS budget and budget change

In the financial year 2004/5, actual spend on CAMHS tiers 2-4 was £431,227k and the predicted budget for 2005/6 was £513,469k. This represented a substantial increase of £82,242k (19%) between 2004/5 and 2005/6. Following on from a reported increase of 24% in CAMHS investment in 2004 and 18% in 2003, it is clear that the national target of a 10% annual growth in investment for the years 2003 to 2005 has not only been achieved but exceeded.

Direct comparisons of spend year on year are problematic because of changes to the way finance data has been collected and yet it is interesting to examine the actual spend reported each year against the predictions made the year earlier. For example, in the 2003 mapping exercise, the predicted CAMHS spend for the financial year 2003/4 was £335,468k whilst the actual spend reported in the 2004 mapping for that year was £322,283k. In the 2004 mapping exercise the 2004/5 actual spend reported was £432,616. This shows that in 2004/5 the actual spend was higher than predicted by £32,707k, or 8%. Local authorities accounted for 32% of the additional spend with the remaining 68% being attributed to additional spend reported by PCTs.

Across the country, increases in investment in CAMHS within SHAs ranged from 12% to 27% (Map 3.1, Table 3.1).

Map 3.1: Budget change 2004/5 and 2005/6 - total tier 2-4 CAMHS budget

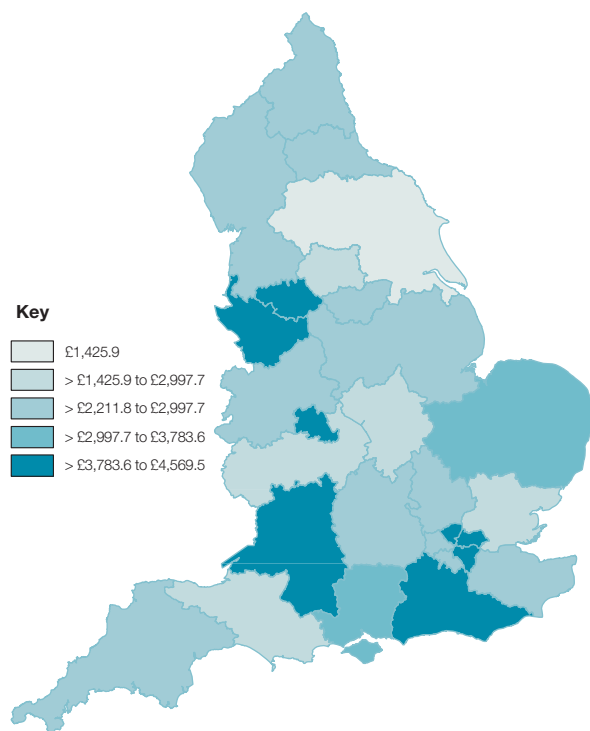
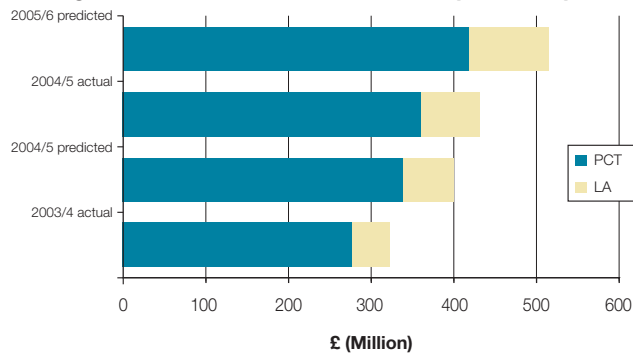


Table 3.1: Total CAMHS Budget change 2004/5 to 2005/6 by SHA

2005	Actual Spend 2004/5 £	Predicted Budget 2005/6 £	Change between 0506 and 0405
Avon, Gloucestershire and Wiltshire	20,278,976	24,619,952	21.40%
Bedfordshire and Hertfordshire	15,214,078	17,703,974	16.40%
Birmingham and the Black Country	16,365,943	20,807,944	27.10%
Cheshire and Merseyside	14,248,681	18,067,341	26.80%
County Durham and Tees Valley	11,229,235	13,794,634	22.80%
Cumbria and Lancashire	12,929,227	15,207,973	17.60%
Dorset and Somerset	6,302,328	7,809,189	23.90%
Essex	13,628,166	15,759,231	15.60%
Greater Manchester	19,104,629	23,014,727	20.50%
Hampshire and Isle of Wight	18,875,184	22,130,055	17.20%
Kent and Medway	14,028,077	16,528,404	17.80%
Leicestershire, Northamptonshire and Rutland	11,986,332	14,116,266	17.80%
Norfolk, Suffolk and Cambridgeshire	17,903,652	21,338,415	19.20%
North and East Yorkshire and Northern Lincolnshire	11,096,497	12,522,407	12.90%
North Central London	19,342,226	23,780,592	22.90%
North East London	20,307,362	24,876,828	22.50%
North West London	20,566,606	23,216,132	12.90%
Northumberland, Tyne and Wear	19,540,231	22,164,090	13.40%
Shropshire and Staffordshire	13,961,196	16,558,969	18.60%
South East London	17,822,108	22,366,348	25.50%
South West London	15,509,797	17,744,706	14.40%
South West Peninsula	9,876,258	12,144,694	23.00%
South Yorkshire	11,337,714	13,822,283	21.90%
Surrey and Sussex	20,202,558	24,388,937	20.70%
Thames Valley	14,198,856	16,953,995	19.40%
Trent	21,065,616	23,506,124	11.60%
West Midlands South	9,294,168	11,504,394	23.80%
West Yorkshire	15,011,048	17,019,993	13.40%
Total	431,226,749	513,468,598	19.10%

PCT investment. In the 2005 mapping exercise PCTs reported £359,902k actual spend for 2004/5 and a predicted budget of £417,854k for 2005/6, a 16% increase in investment. This represented an 83% and 81% share of the CAMHS budget in the respective financial years, a drop from the investment recorded in the 2004 mapping exercise when PCTs reported commissioning an 86% share of the total actual spend for 2003/4 and an 85% share of the predicted budget for 2004/5 (Fig. 3.1).

Fig. 3.1: PCT and LA share of actual spend and predicted spend

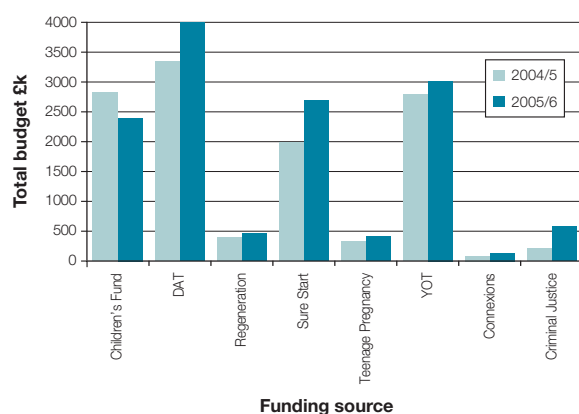


LA investment. In the 2005 mapping exercise local authorities reported actual spend of £71,324k for 2004/5 and a predicted budget of £95,615k for 2005/6, an increase of 34%. This represented a 17% and 19% share of the CAMHS budget in the respective financial years. In the 2004 exercise local authorities reported £43,793k actual spend in 2003/4 and £60,790k predicted budget for 2004/5 (a 14% and 15% share of the CAMHS budget in the respective financial years) (Fig. 3.1). This is partly due to the increased involvement of local authorities in the 2005 exercise, as noted above.

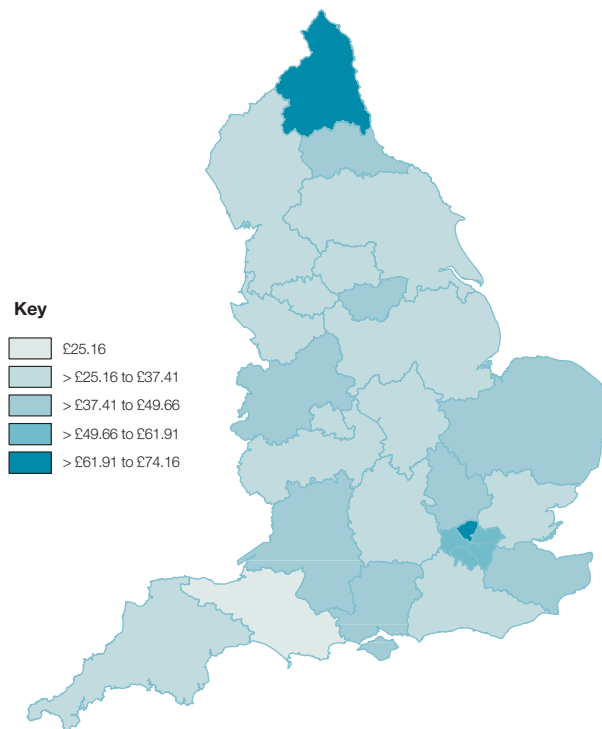
3.2 Source of non-mainstream funding

The principal sources of the CAMHS budget was mainstream funding from PCTs and local authorities. This accounted for 94% of the total CAMHS actual spend in 2004/5. This amounted to £407,852k in 2004/5, whilst in 2005/6 it was predicted to be £482,891k (93%). Of the remainder, the key sources were Youth Offending, Sure Start/Children's Centres, the Children's Fund and Drugs and Alcohol funding. The only source decreasing was the Children's Fund. All other sources of income were expected to increase (Fig. 3.2).

Fig. 3.2: Trends in CAMHS non-mainstream funding sources



Map 3.3: Spend per child 0-17 years old 2004/5



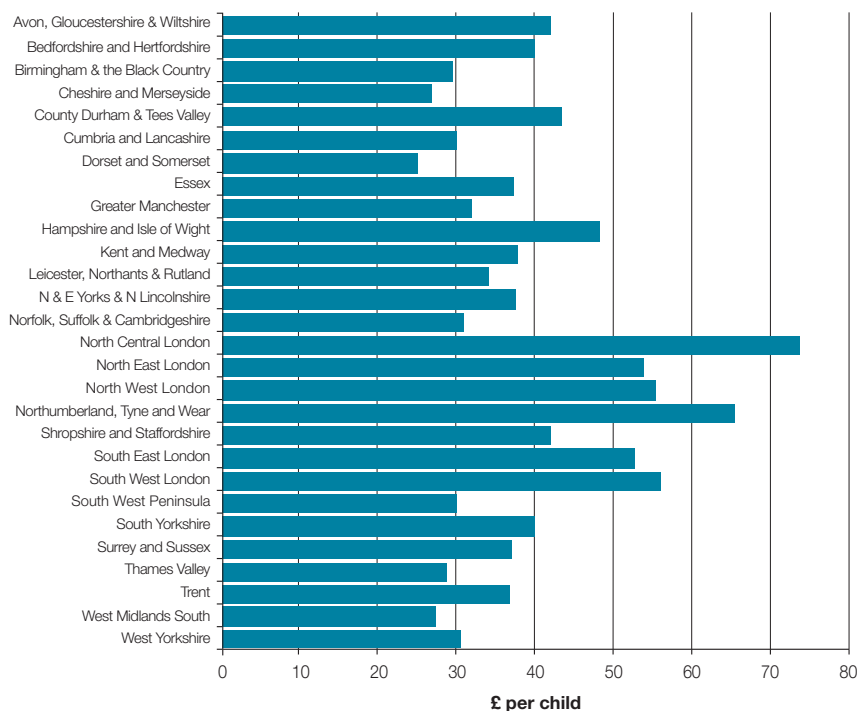
3.3 Spend per child

The average spend per child aged 0 to 17 nationally was £46.33 in 2005/6, an increase of over £7 on the £38.91 reported for 2004/5 but throughout SHAs a large range was found, from £74.17 to £25.16 in 2004/5 (Map 3.3 and Fig. 3.3).

Average PCT spend per child was £32.46 in 2004/5 whilst average local authority contribution per child was £6.44.

When the spend per child was examined in terms of provision for the local population only (taken from the costs of teams with a local catchment area), a significant reduction of spend was apparent. This was largely due to the high cost of tier 4 provision. Average spend on local teams was £29.26 per child, an increase of nearly £4 on the £25.36 reported in 2004. This ranged from £57.57 to £16.59 in SHA areas.

Fig. 3.3: Spend per child 0-17 years old 2004/5

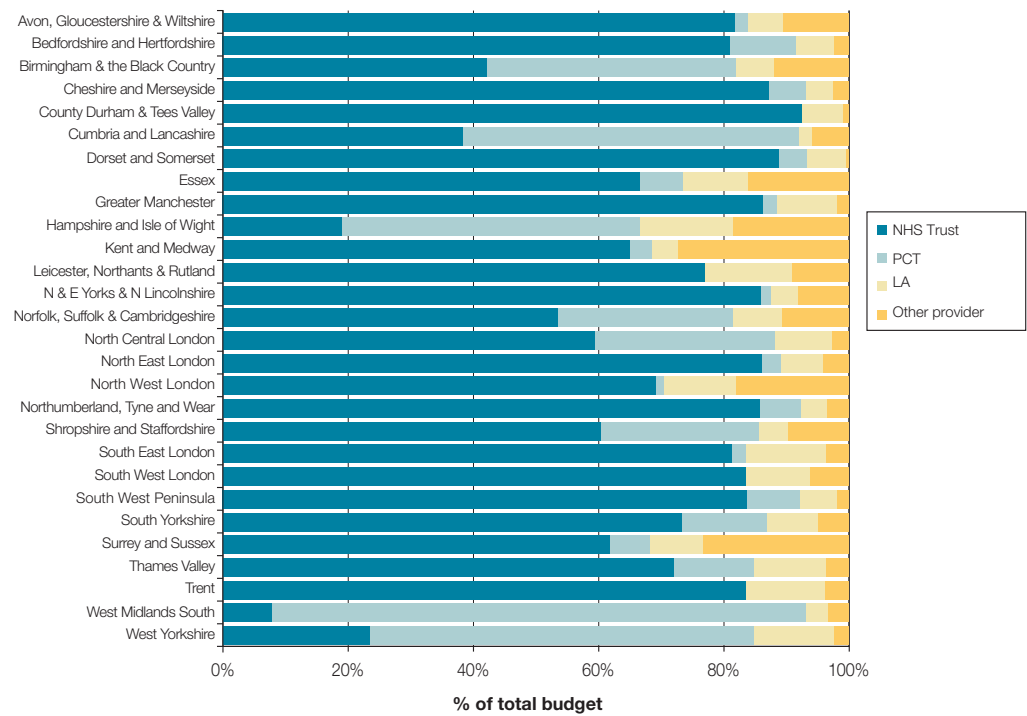


3.4 Provider share of funding

NHS provider trusts remained the main providers of CAMHS in 2004/5. Overall NHS Trusts received 68% of the commissioning budget, PCTs received 15%, local authorities 9%, and 8% went to ‘other’ providers (Fig. 3.4). ‘Other’ providers included independent sector tier 4 provision and voluntary agencies.

‘NHS trusts’ in this analysis included any type of NHS acute, community or specialist mental health provider trust. The last category was the most numerous.

Fig. 3.4: Provider share of budget 2004/5



Chapter 4:

Caseload and case characteristics

The PSA target to achieve growth of more than 10% annually in the activity delivered by CAMHS has been measured in terms of increases in the caseload managed by CAMHS staff. This chapter summarises information collected on caseload in the mapping including data on caseload size, the length of time cases have waited to be seen and the length of treatment. Attention is also given to key characteristics of the children and young people making up the caseload. The caseload recorded was that of a sample period only. This was the calendar month of November 2005 for tier 2 and 3 teams and the 6-month period 1st June to 30th November 2005 for tier 4 teams. The chapter is structured as follows:

A: Summary data:

4.1 National maps of caseload per 100k population

B: Waiting times reported in terms of:

4.2 New cases seen

4.3 Cases waiting and length of wait

4.4 Length of treatment

C: Case characteristics:

4.5 Age and gender

4.6 Ethnicity

4.7 Primary presenting disorder

4.8 Referral source

Detailed tables of the data used in the following chapter can be found on the CAMHS mapping website at:

www.camhsmapping.org.uk/2005

All figures and maps correspond to tables of the same number on the website.



4.1 Summary of activity

Definitions for activity

Cases: A 'case' is a child, or a young person, or a child / young person and their family, for which a referral has been received and with whom CAMHS staff have actively been working. Where separate referrals were received for one or more siblings in a family, each sibling was counted as a separate case.

Active work: Active work includes any of the following activities: assessment, treatment, case management, liaison, consultation, case support and health promotion. The frequency with which cases were seen during the study period was not collected during the 2005 mapping exercise.

Consultation: A consultation requires a specialist CAMHS clinician to provide clinical advice or information for which they can be held accountable. This will usually infer that a record of the consultation will be recorded by at least one party.

Data collection period:

Tier 2/3 teams: caseload data were collected from the 1st to 30th November 2005.

Tier 4 teams: caseload data were collected for the six-month period June 1st to November 30th 2005.

Caseload: The caseload is a count of the total number of cases a team worked with in the data collection period. This is collected at the team level only. If a number of staff within a team work with the same case it should be counted once. The team caseload is effectively a head count of those active cases that have been worked with in the sample period.

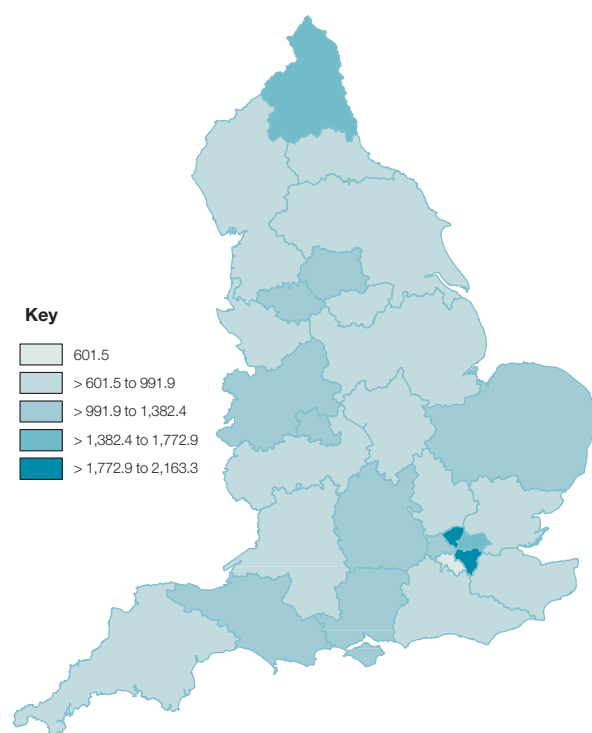
Note: a number of services reported having teams with no caseload during the data collection period due to the newness of the team (staff were in post but the team was not yet operational), posts being vacant, staff being on long-term sick/maternity leave or the activities of the team excluded casework.

In the mapping, caseload was used as a proxy for activity in CAMHS and it was measured using the 'active' caseload for a sample period (see definition). An active case was a child or young person (and/or their family) who was seen by a member of staff of a CAMHS team for the purposes of assessment, treatment, monitoring, support or advice/health promotion. An active case might also be one on which a CAMHS professional was consulted, as an important role for tier 2-4 CAMHS teams is to provide specialist advice for staff working in non-specialised services.

Therefore, the caseload was simply a headcount of children and young people who received support, treatment and care from specialist CAMHS professionals. It did not reflect either the number of staff who had been involved in the case/intervention, or the intensity of the care provided.

A total of 112,984 cases were reported in 2005, an increase of 7% on the 104,744 cases reported in 2004, and an increase of 31% on the 86,521 cases reported in 2003. Examined against the population of 0-17 year olds, the rate per 100k population receiving care nationally was 1,020. This varied substantially between SHAs ranging from under 601 to 2,163 (Map 4.1a).

Map 4.1a: CAMHS caseload per 100k population aged 0-17 years old



4.2 New cases seen

New cases: A new case was an active case that had been seen for the first time during the data collection period.

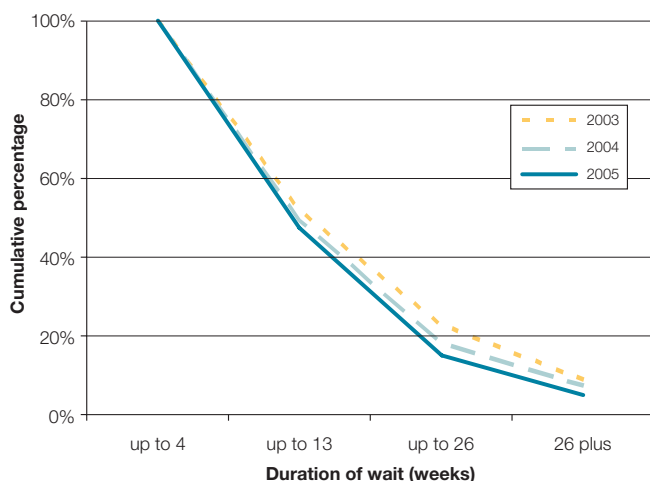
Length of wait: Duration of wait is the interval between the receipt of the referral request and the time the case is first seen. In the case of DNAs or cancellations, the wait is recorded from the most recent DNA or cancellation.

In total there were 31,279 new cases reported in the 2005 exercise. This was an increase of 12% on the 27,892 new cases reported in 2004 and a 91% increase on the 16,362 new cases reported in 2003. Taken as a proportion of total recorded caseload, cases identified as being 'new' increased from 19% in 2003, to 27% in 2004 and 28% in 2005. There were 28,558 new cases in tier 2/3 teams, and 2,721 new cases in tier 4 over the sample periods.

The majority of new cases (52%) were reported as having waited less than 4 weeks to be seen by a CAMHS team. This showed a continuation of the improvement in waiting times detected in the 2004 and 2003 mapping when a wait of 4 weeks or less was experienced by 51% and 48% of new cases respectively.

The proportion of the caseload that had to wait up to 3 months increased slightly to 32%, from 29% in 2003 and 31% in 2004. Waits of up to 6 months were down from 14% in 2003 to 11% in 2004 and 10% in 2005 of new cases. Waits over 6 months were similarly down from 9% in 2003 to 8% in 2004 and to only 5% in 2005 (Fig. 4.2a).

Fig. 4.2a: Length of wait for new cases seen 2003 - 2005 (cumulative percentages)



The number of new cases waiting had risen in line with the increase in size of the CAMHS caseload. 16,367 new cases had waited 4 weeks or less compared to 14,119 in 2004 and 10,107 new cases had waited up to 3 months compared to 8,683 in 2004. When the number of new cases waiting for longer periods was examined they were found to be down. The number of new cases waiting over 6 months in 2005 was 1,682 compared to 2,109 in 2004. Therefore more new cases had been seen in the mapping sample period than previously and they had waited a shorter time to be seen.

The total tier 2/3 team caseload was 108,059 of which 28,558 cases (26%) were new in the study period, although this varied across SHAs ranging from 15% to 45% (Fig. 4.2b). It is clear from Fig. 4.2c that services in some SHAs were able to respond to demand for tier 4 care very quickly and lengthy waits of over 6 months were very rare, continuing a trend observed in the 2004 CAMHS report.

Fig. 4.2b: Length of wait for new cases accessing tier 2/3 teams

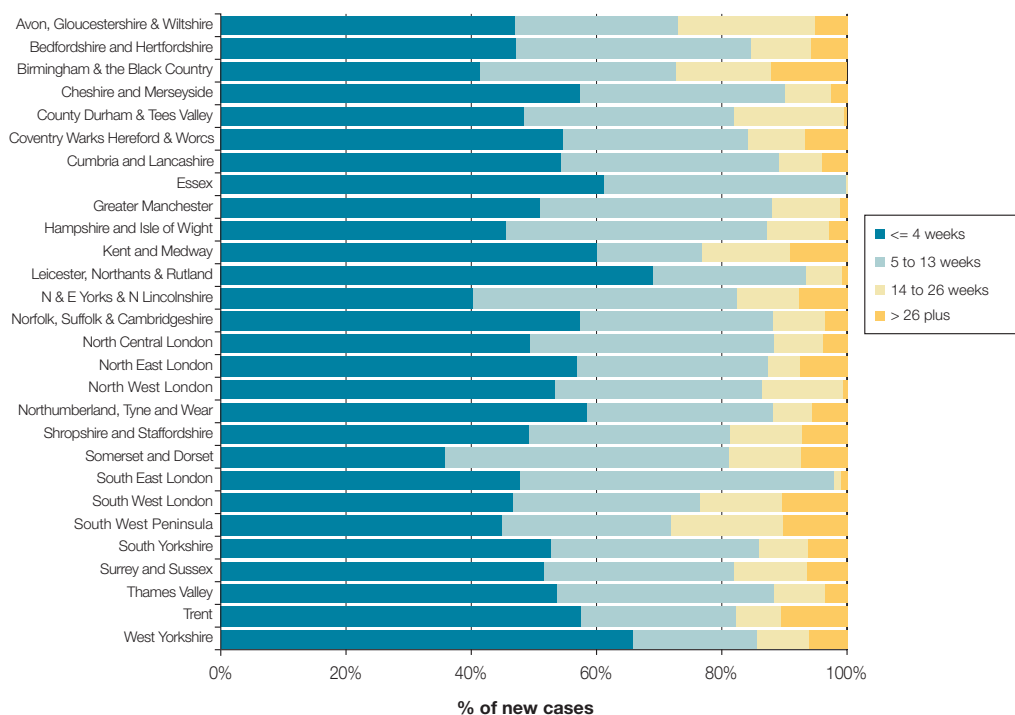
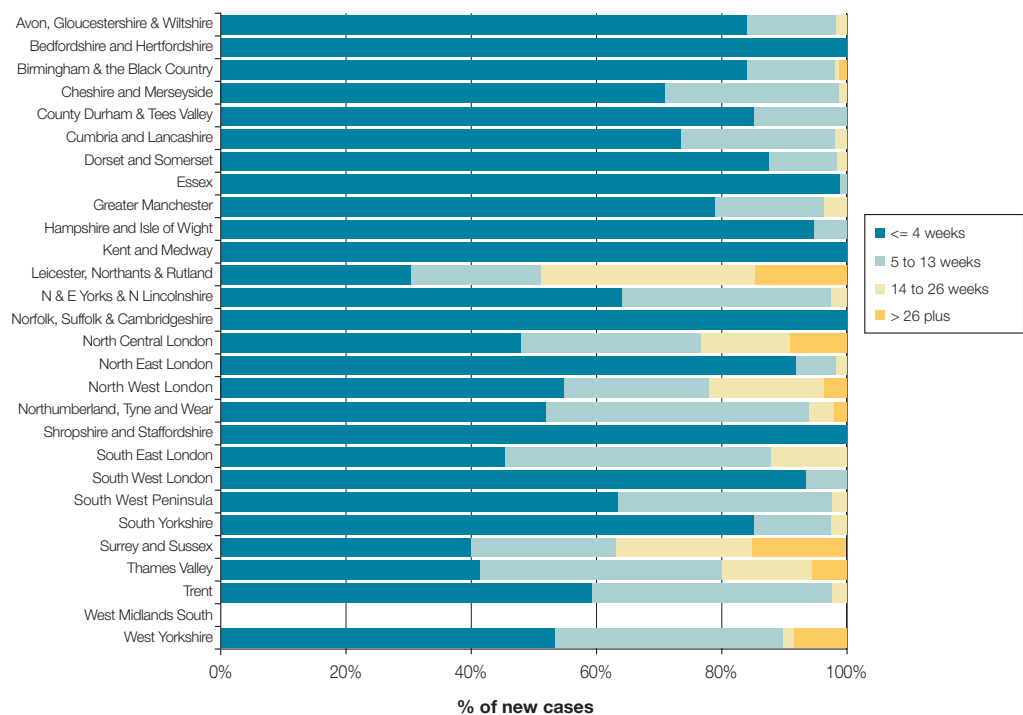


Fig. 4.2c: Length of wait for new cases to tier 4 teams



4.3 Cases waiting and length of wait

CAMHS teams reported 26,199 cases waiting to be seen at the end of the data collection period in 2005. These were cases that had been referred to a CAMHS teams, but had not yet been seen by that team. This marked a continued fall in the number of cases waiting from 30,716 in 2004 and 28,880 in 2003. As a proportion of active caseloads this was 23% in 2005, 29% in 2004, and 34% in 2003.

The number of children and young people who had been waiting up to 4 weeks had increased from 8,049 in 2003 to 9,143 in 2004 but fell to 9,050 in 2005. The numbers waiting 4 to 13 weeks rose from 9,320 in 2003 to 10,036 in 2004 but fell to 8,478 in 2005. The numbers waiting over 6 months rose from 5,261 in 2003 to 6,134 in 2004 but fell to 4,030 in 2005. The number of children waiting for between 3 to 6 months went down from 6,250 in 2003 to 5,403 in 2004 but fell to 4,641 in 2005. However, the pattern of waits for tier 2/3 and tier 4 teams was found to be very different (Figs. 4.3a and b).

Fig. 4.3a: Trend in cases waiting for 2/3 teams

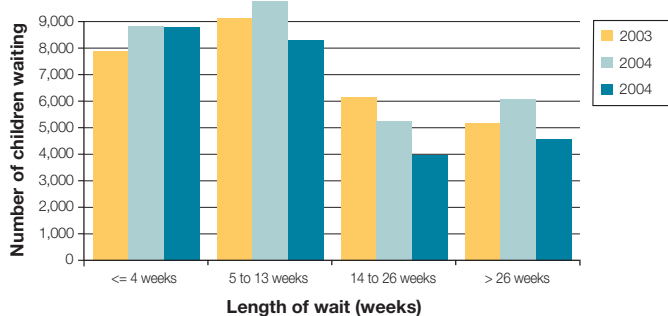
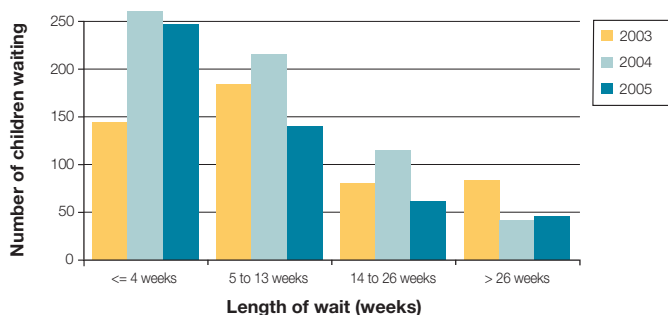


Fig. 4.3b: Trend in cases waiting tier 4 teams



The total number of cases waiting for tier 2/3 teams was 25,705 in 2005, (24% of the active caseload). Of the caseload waiting, 34% had waited up to 4 weeks, 32% up to 3 months, 15% between 3 and 6 months and 18% over 6 months. Almost all SHAs had cases that had waited for 6 months or more (Fig. 4.3c).

Only 494 cases were waiting for tier 4 teams at the end of the study period emphasising the very specialist nature of these teams and the small number of referrals made to them. Predominantly waits were under 3 months, 50% were under 4 weeks and 28% between 5 and 12 weeks. 9% of cases had waited over 6 months (Fig. 4.3d). Although the mapping does not track the care pathways of cases, it is understood that cases with long waits for a specific tier 4 service, would already be receiving some support from a CAMHS team.

Fig. 4.3c: Length of wait for cases waiting tier 2/3 teams

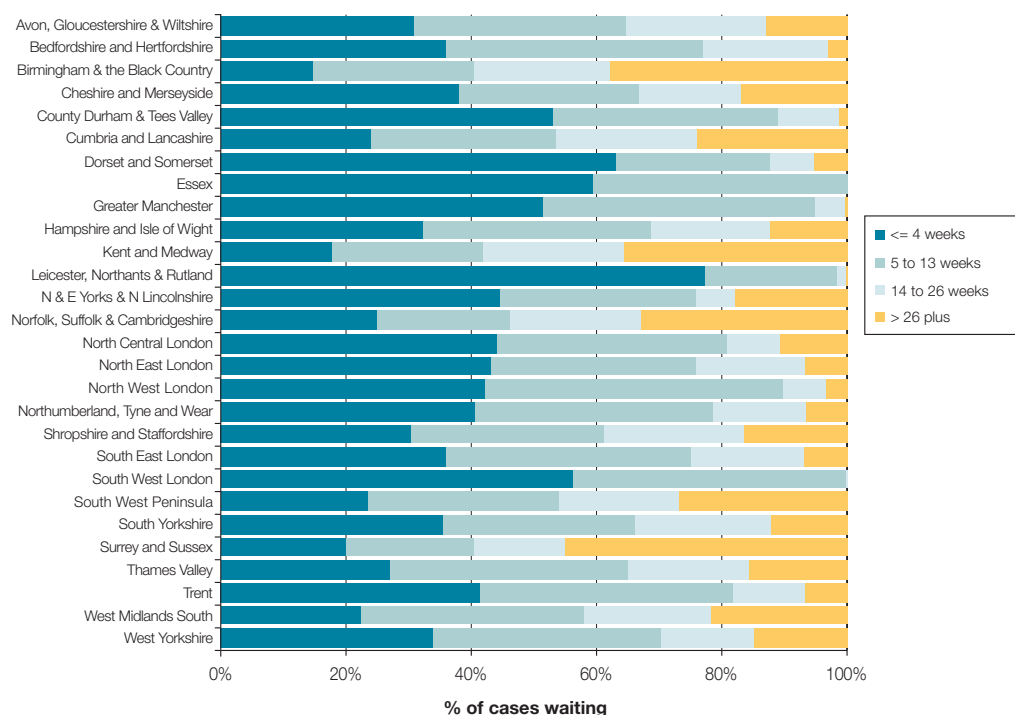
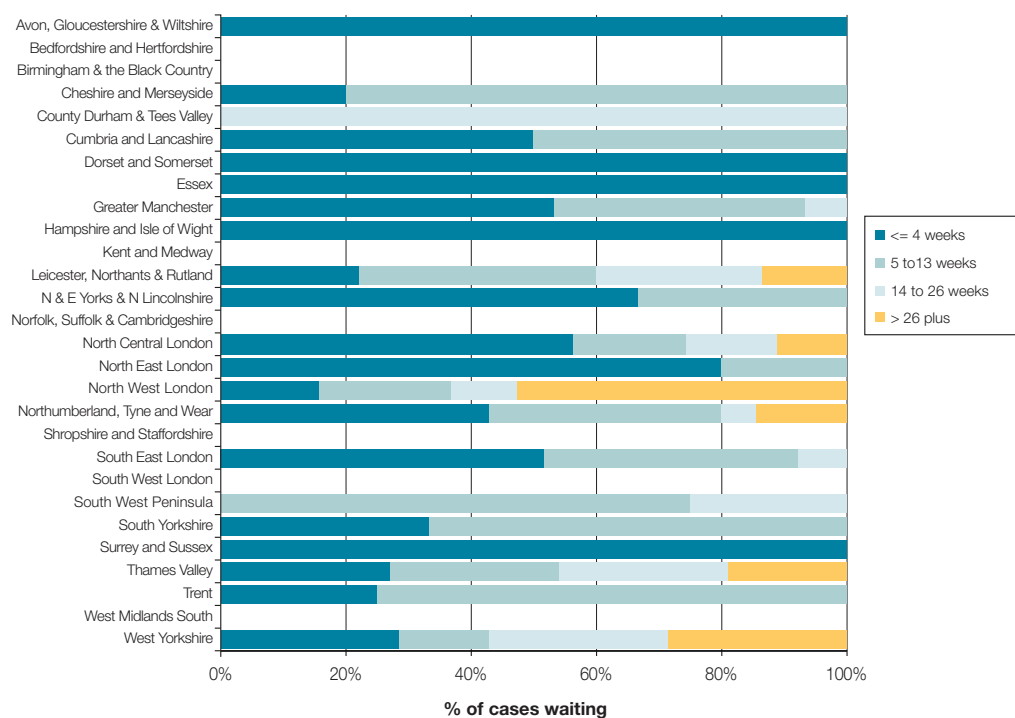


Fig. 4.3d: Length of wait for cases waiting tier 4 teams



4.4 Length of treatment

Duration of treatment measures how long a case had been seen for, or, if the case was closed in the sample period, how long that case had been active. This was reported from the date the case was first worked with up until 30th November 2005, or until the case was closed. Information on the length of treatment was reported for 110,832 cases overall, 2,152 cases (2%) less than the reported active total caseload.

Trends indicate that interventions were longer (Figs. 4.4a and b) in 2005 than they were in 2003. However, interventions were marginally shorter in 2005 as compared with 2004. The proportion of the caseload which had been seen for 4 weeks or less decreased by 4% from 25% in 2003 to 21% in 2004. There was a small increase in 2005, with 22% of cases reported as seen for 4 weeks or less. The proportion of cases receiving treatment of 1 to 3 months went down by 2% between 2003 and 2004 to 22%, but then increased to 23% in 2005. However, during the same period, the proportion of cases receiving treatment of 6 months or over increased. Because evidence of this was collected in 2003, an additional category was added to the mapping in 2004 to identify the delivery of treatment of over 1 year in length. In both 2004 and 2005, it was found that 22% of active cases of tier 2/3 teams were of at least one year in duration and 18% of tier 4 teams.

There was evidence that a similar approach to treatment times was being taken nationally by the staff of generic, targeted and dedicated worker provision that make up tier 2/3 CAMHS teams (Fig. 4.4c). The length of treatment provided by tier 4 teams was more variable across SHAs reflecting the differing nature and location of tier 4 teams (Fig. 4.4d).

Fig. 4.4a: Length of treatment in tier 2/3 teams

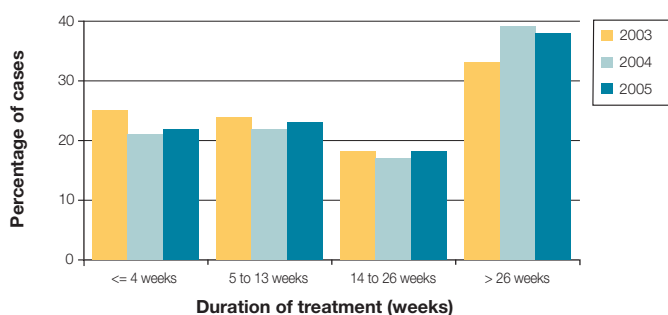


Fig. 4.4b: Length of treatment in tier 4 teams

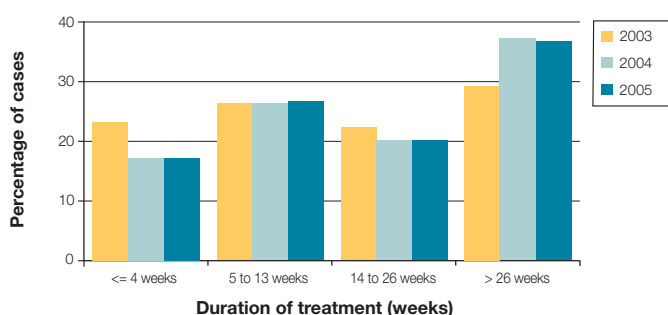


Fig. 4.4c: Length of treatment in tier 2/3 teams

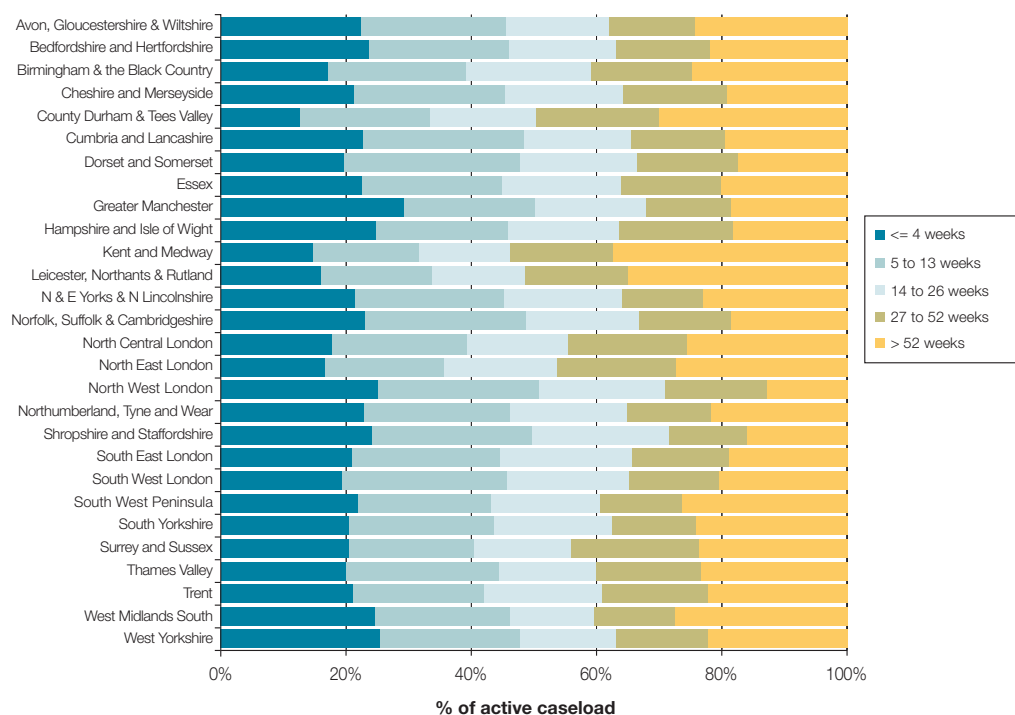
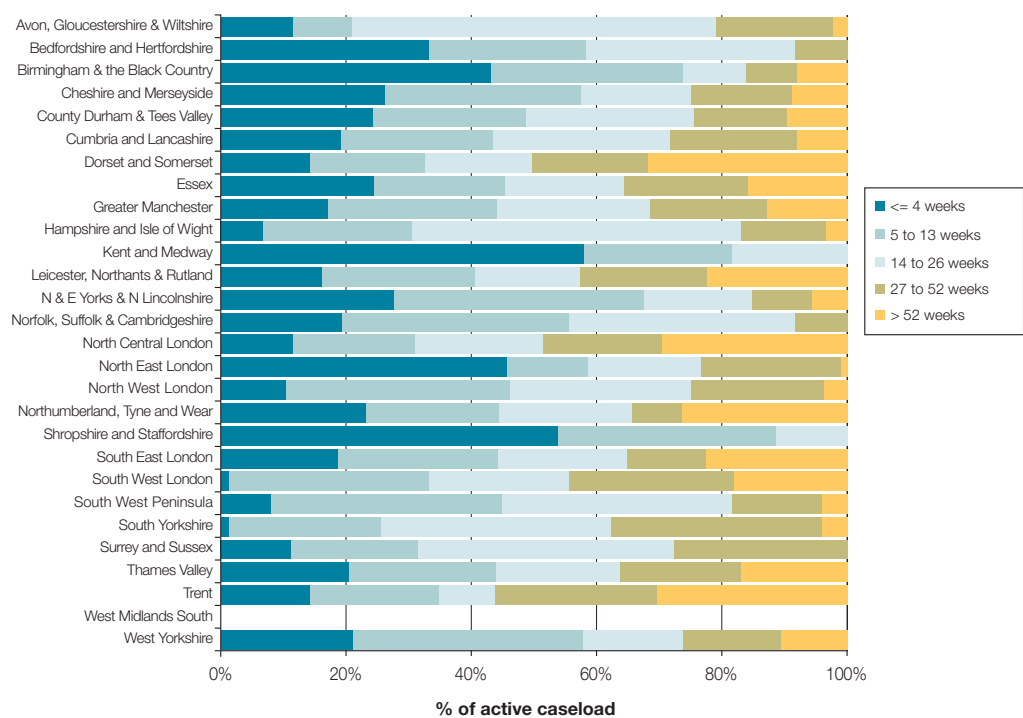


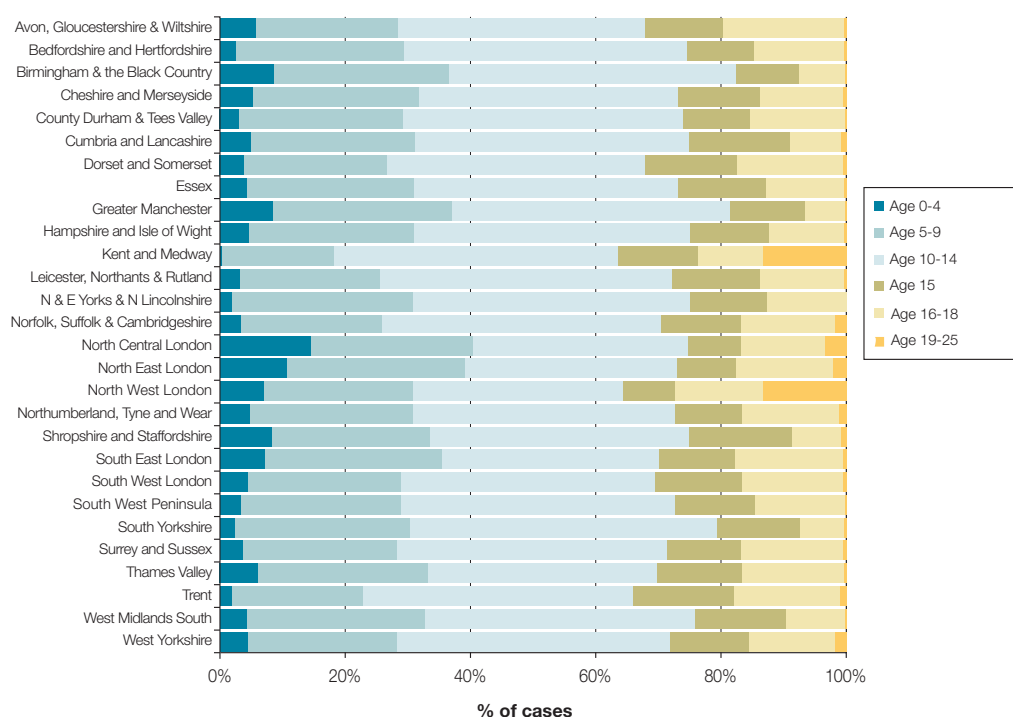
Fig. 4.4d: Length of treatment in tier 4 teams



4.5 Age and gender profile

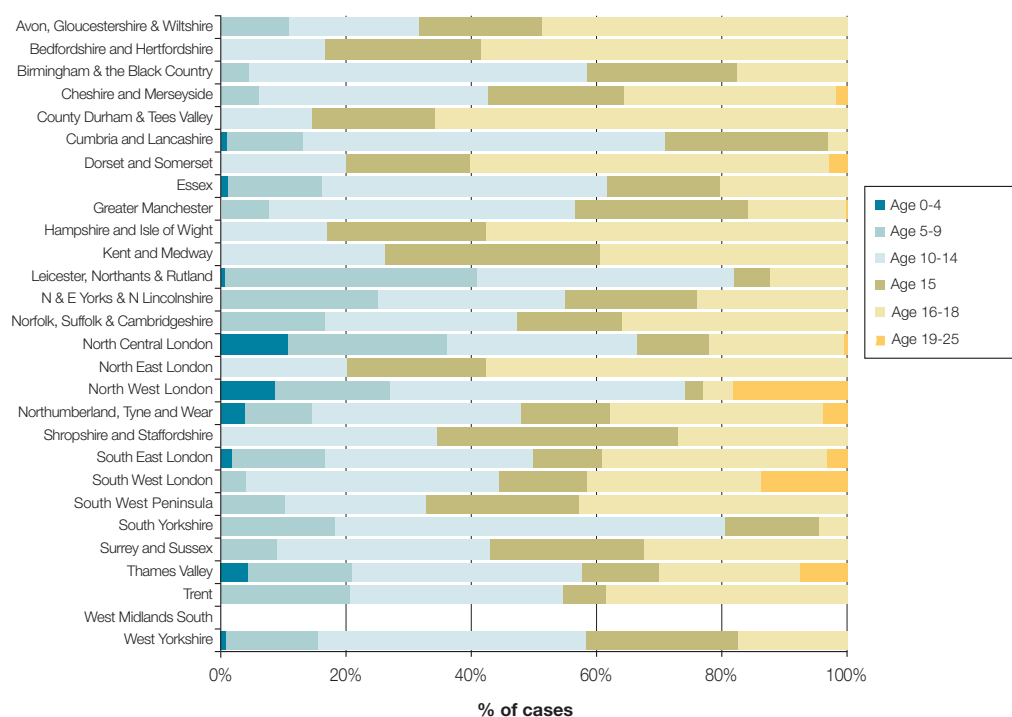
The age profile of children and young people using CAMHS has remained very similar throughout the sample period in each of the three years of mapping. As this would be expected this suggests high validity of the data. In tier 2/3 teams the proportion of young people aged 16 to 18 increased from 12% to 13% and the proportion aged 19 to 25 rose from 1% to 2%. The variation between SHAs in the age range of service users of tier 2/3 teams remained small (Fig. 4.5a).

Fig. 4.5a: Age profile of service users of tier 2/3 teams (N=108,006)



Clear differences can be seen between the age profile of service users of tier 4 teams and tier 2/3 teams (Fig. 4.5b). Owing to the nature of the services provided, Tier 4 teams were more likely to be providing for young people and the emphasis on this provision could be seen in some localities.

Fig. 4.5b: Age Profile of service users of tier 4 teams (N=4,981)



A total of 66,658 cases (59%) were identified as male, and 46,329 cases (41%) were identified as female. Overall 59% of the children and young people using tier 2/3 teams were male and the gender profile by SHA was remarkably consistent nationally (Fig. 4.5c).

The gender profile of tier 4 team service users was more variable. This reflected the provision in SHAs of services, such as those for eating disorders, which tend to have a more gender specific client group. Overall, 54% of tier 4 users were male (Fig. 4.5d).

Fig. 4.5c: Gender of service users of tier 2 to 3 teams (N=108,006)

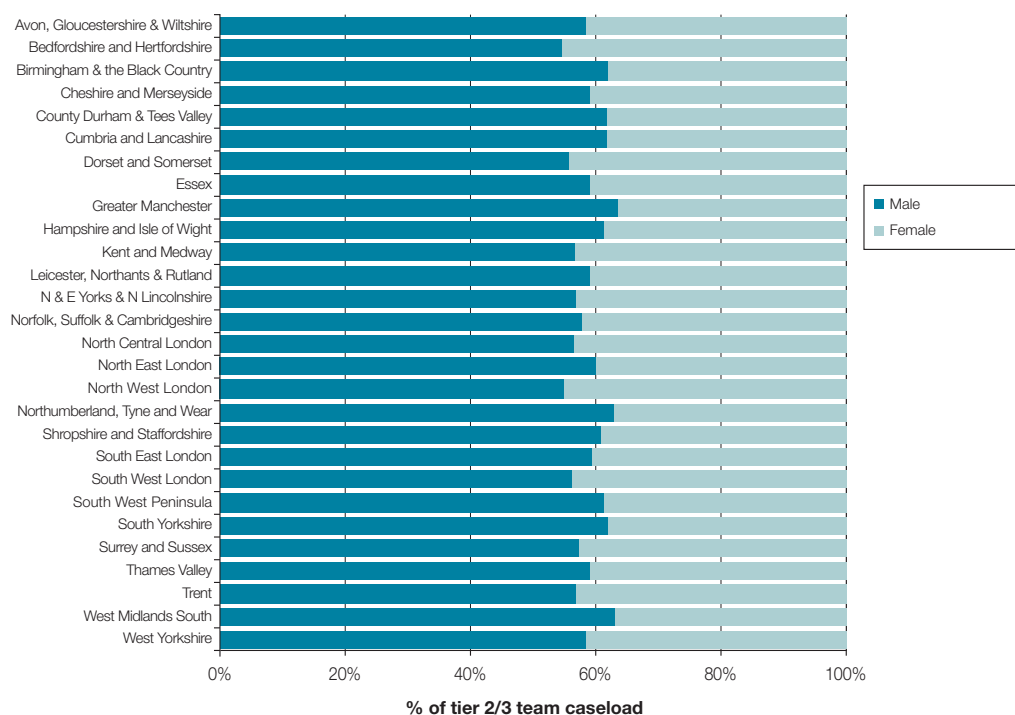
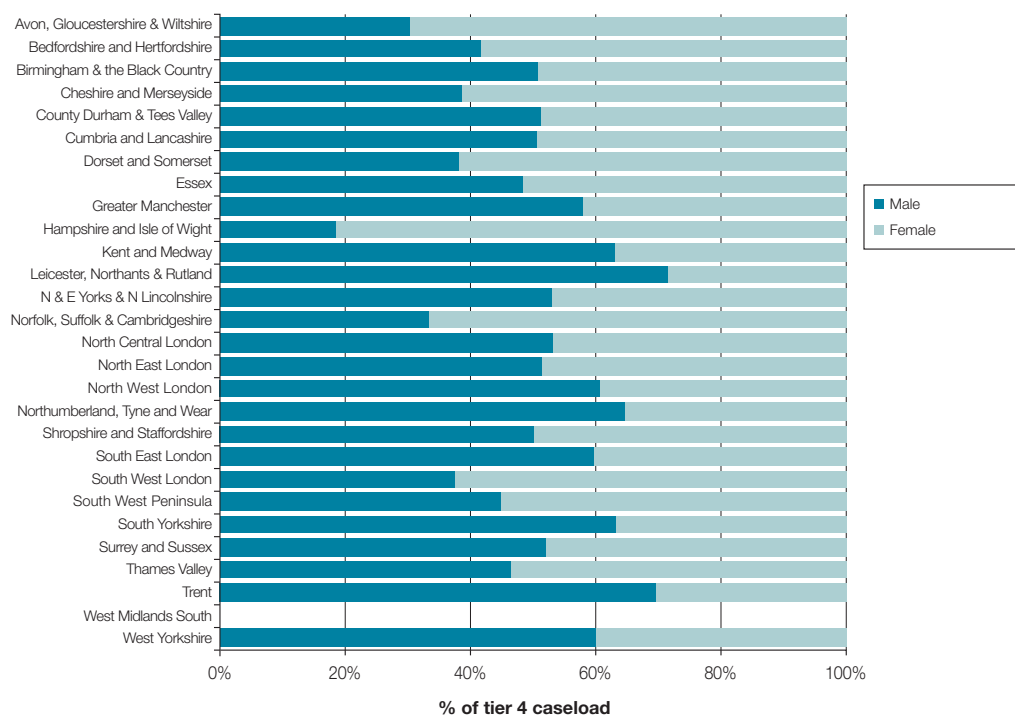


Fig. 4.5d: Gender of service users of tier 4 teams (N=4,981)



4.6 Ethnicity

The ethnic profile of the children and young people using CAMHS has changed very little in the last 3 years. The most significant change was an increase in the number of cases with no ethnicity indicated. This rose from 2% in 2003 to 8% in 2004 and 10% in 2005. The principle reason for this increase in non-responses was the inclusion of consultation cases for which full details of case characteristics were not always recorded by the professional being consulted as files on the case might not be held by that team.

Excluding cases where ethnicity was not stated, 87% of cases were white, a reduction of 1% from 2003 and 2004 (Fig. 4.6a). There appears to be an increase in the number of black and minority ethnic communities (BME) that used tier 4 services in 2005 (Fig. 4.6b).

Not only were there important differences in the ethnicity of the CAMHS caseload between SHAs, but there were also significant differences in the number of cases whose ethnicity was 'not stated' across the SHA areas (Fig. 4.6c and 4.6d).

Fig. 4.6a: Trends in ethnicity of service users in tier 2/3 teams by SHA

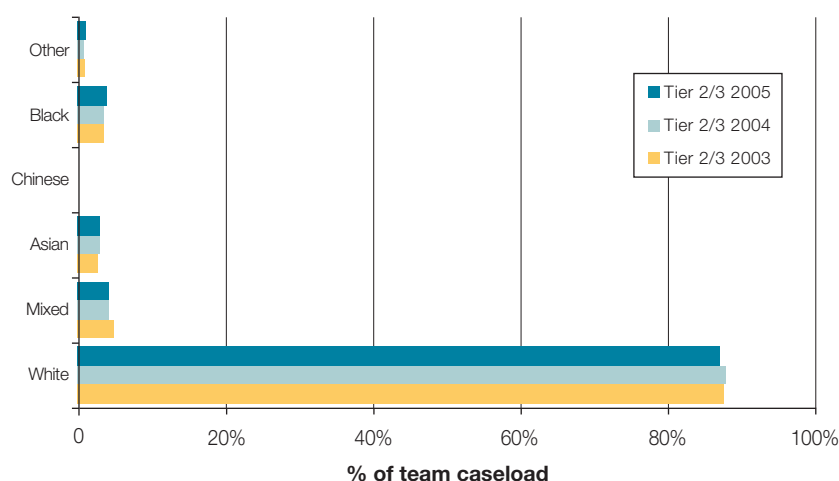


Fig. 4.6b: Trends in ethnicity of service users in tier 4 teams by SHA

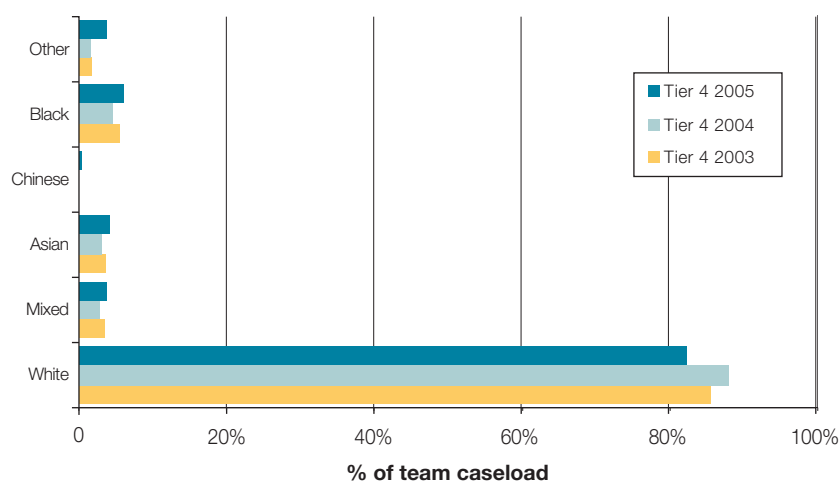


Fig. 4.6c: Ethnicity of tier 2/3 team cases (CN = 107,194)

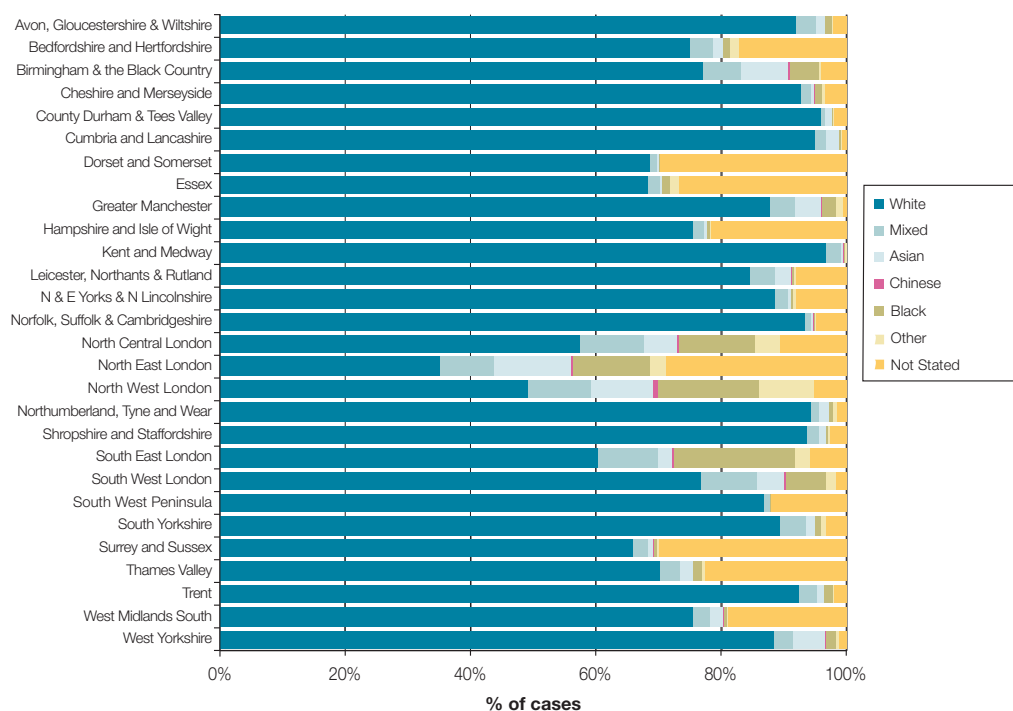
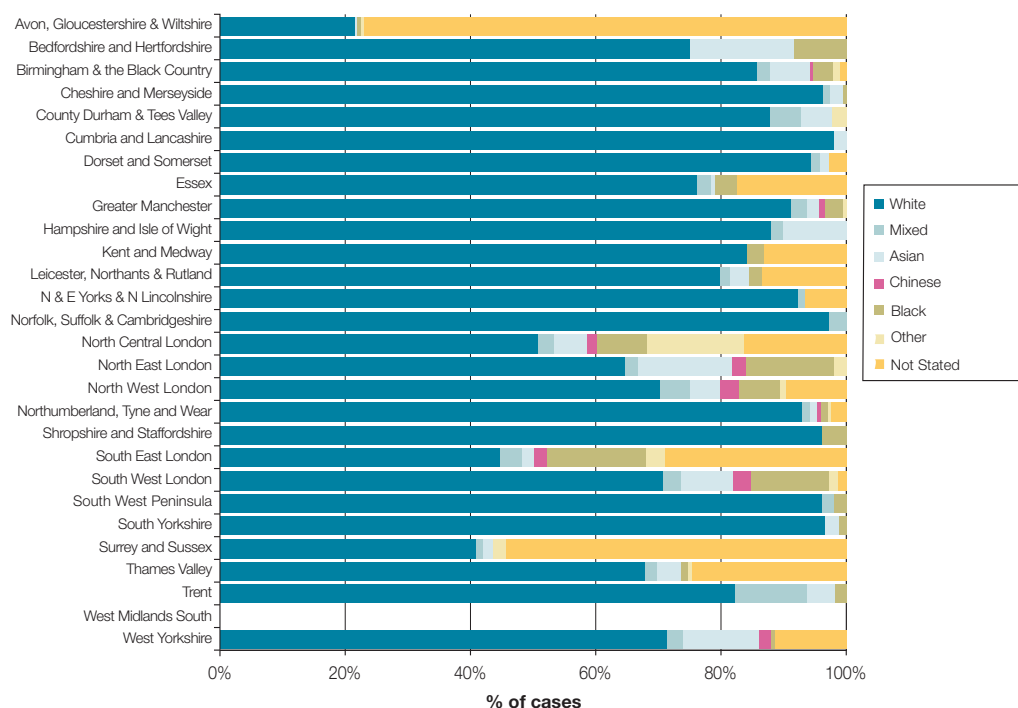


Fig. 4.6d: Ethnicity of tier 4 team cases (N=5,123)



4.7 Primary presenting disorder

There was very little change in the primary presenting disorders recorded for the CAMHS caseload from previous years. Emotional disorders accounted for 32% of tier 2/3 cases, and 21% of tier 4 cases. Conduct disorder (13%) and hyperkinetic disorder (12%) remained the next most common reasons for referral within tiers 2/3, whilst eating disorder (16%) was the next most common reason for referral in tier 4 (Figs 4.7a and b).

Fig. 4.7a: Primary presenting disorder of service users of tier 2/3 teams (N=109,257)

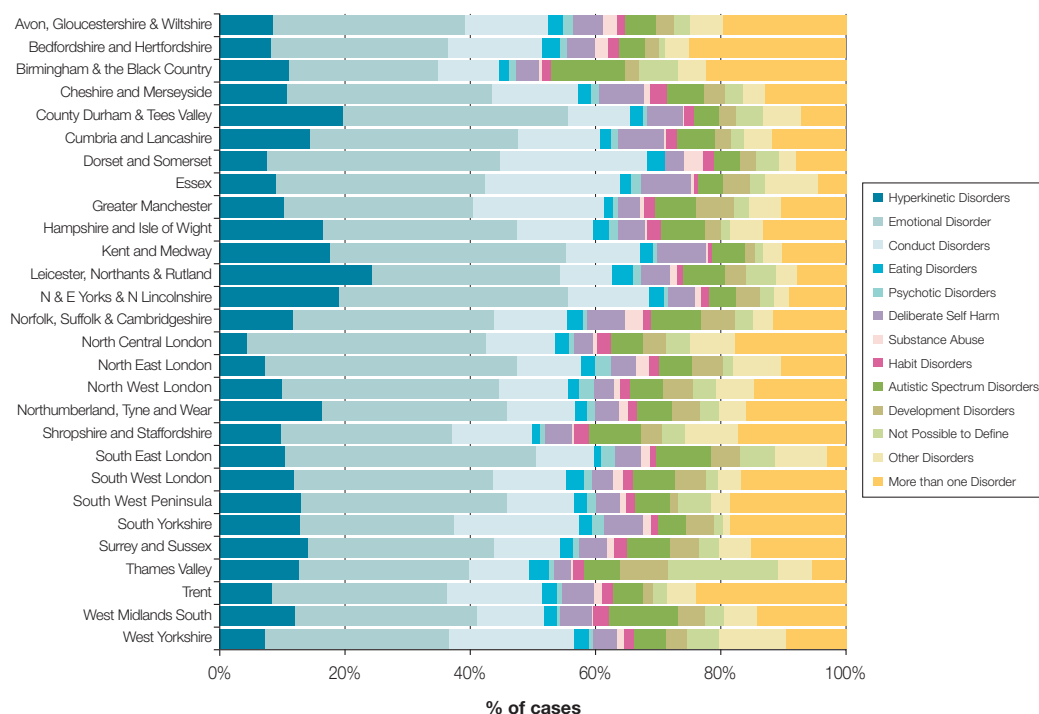
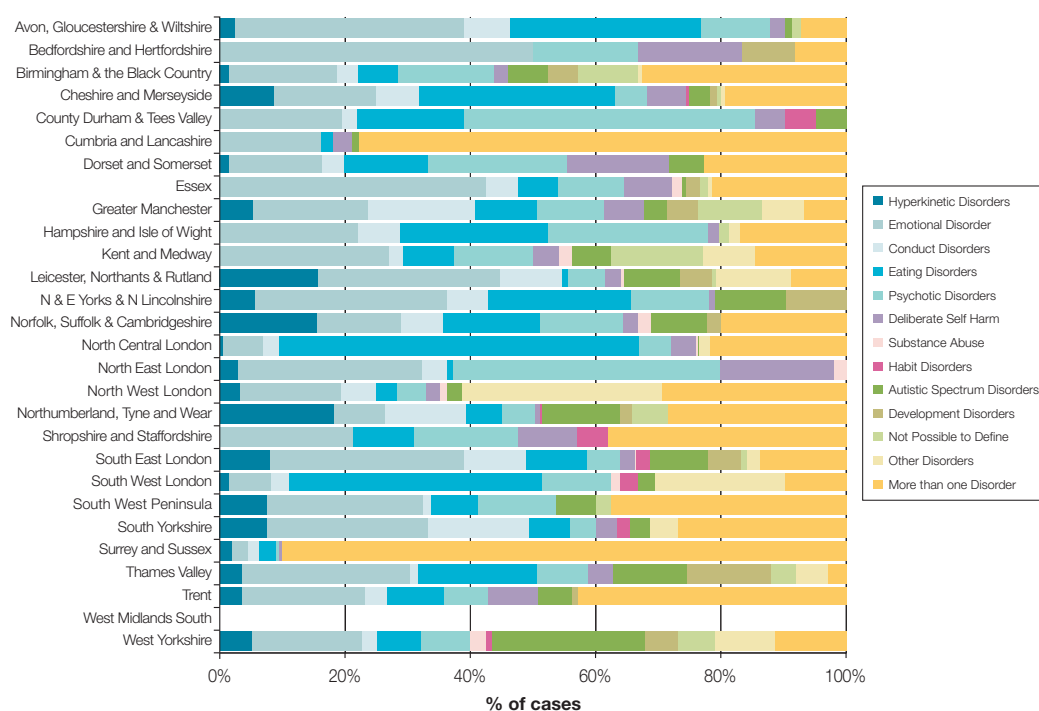


Fig. 4.7b: Primary presenting disorder of service users of tier 4 teams (N=4,829)



4.8 Referral source

Approaching half of all tier 2/3 referrals came from primary health care (44%), a further 15% came from child health services, whilst 11% of cases came from both education and social services (Fig 4.8a). The proportion of referrals from primary care had fallen by 4% from 48% of tier 2/3 referrals reported in both 2003 and 2004. The highest number of tier 4 referrals were internal referrals (38%), followed by referrals from other trusts (25%) (Fig. 4.8b).

Fig. 4.8a: Referral source of service users of tier 2/3 teams (N=107,139)

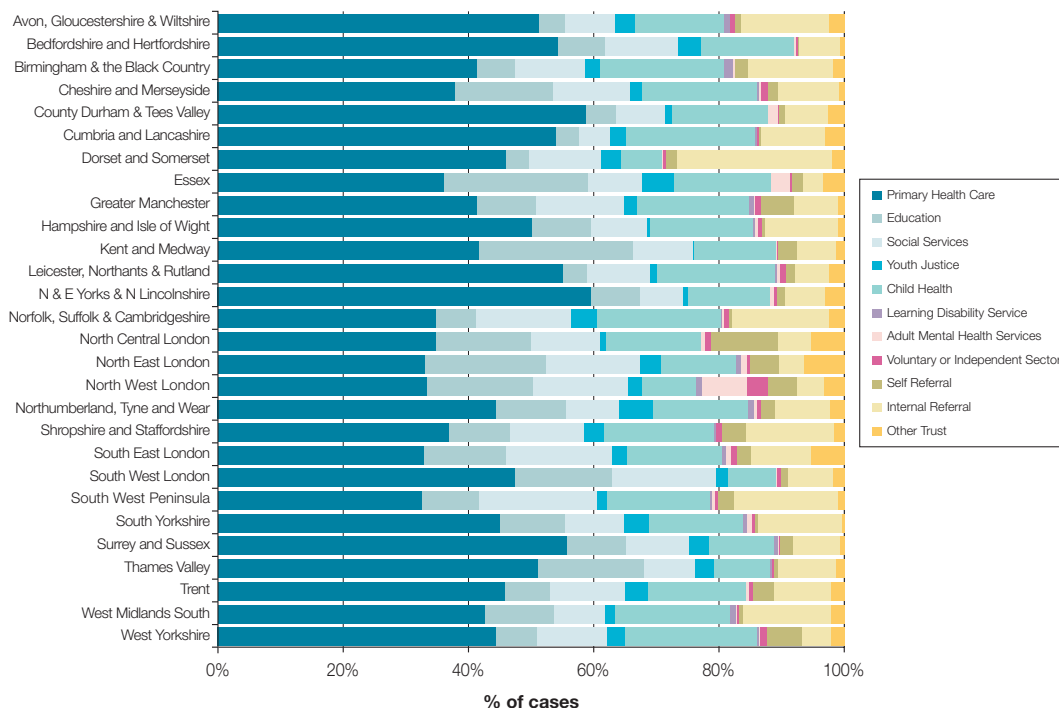
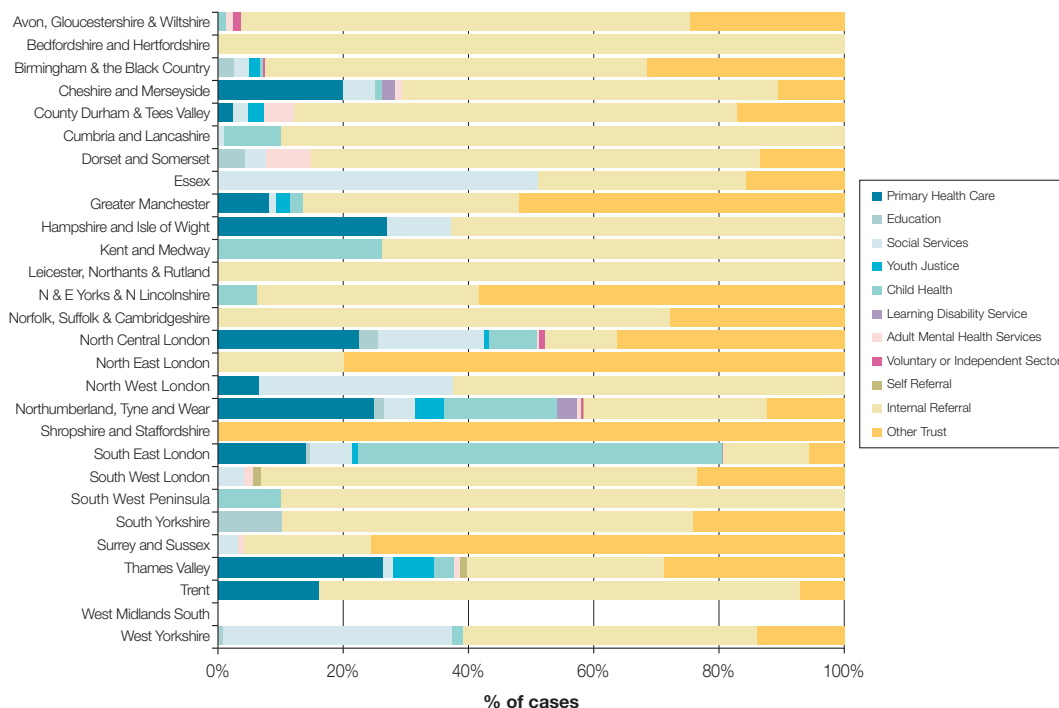


Fig. 4.8b: Referral source of service users of tier 4 teams (N=4,973)



Chapter 5:

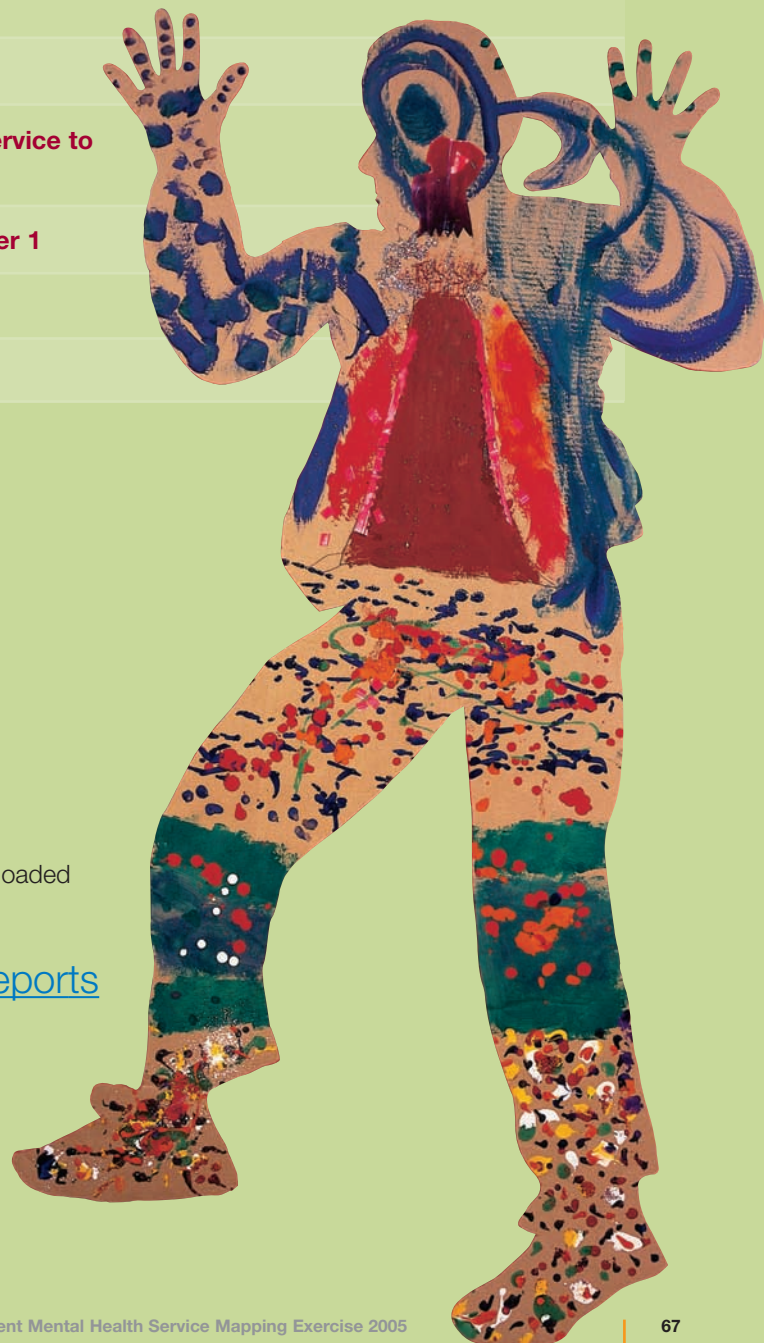
Workforce

In this section the CAMHS workforce is examined. It covers:

- 5.1 CAMHS workforce overview**
- 5.2 Professionals in the CAMHS workforce**
- 5.3 Local and wider than local teams**
- 5.4 Workforce patterns within local teams**
- 5.5 Workforce patterns in teams delivering a service to a wider area**
- 5.6 How specialist CAMHS Teams support to tier 1**
- 5.7 Care Staff**
- 5.8 National vacancy rates by profession**

Detailed tables of the data used can be found and downloaded from the CAMHS mapping website at:

www.camhsmapping.org.uk/2005/reports

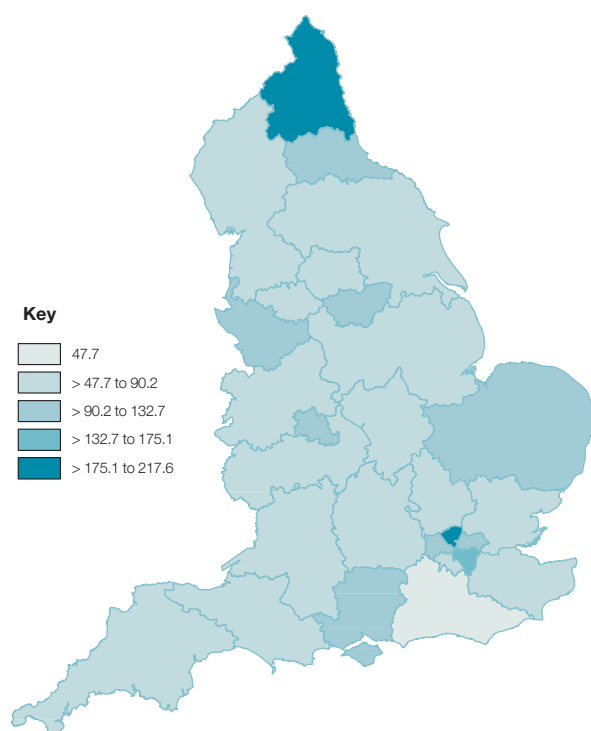


5.1 CAMHS workforce overview

The total workforce reported in the 2005 CAMHS mapping was 9,876 WTE.

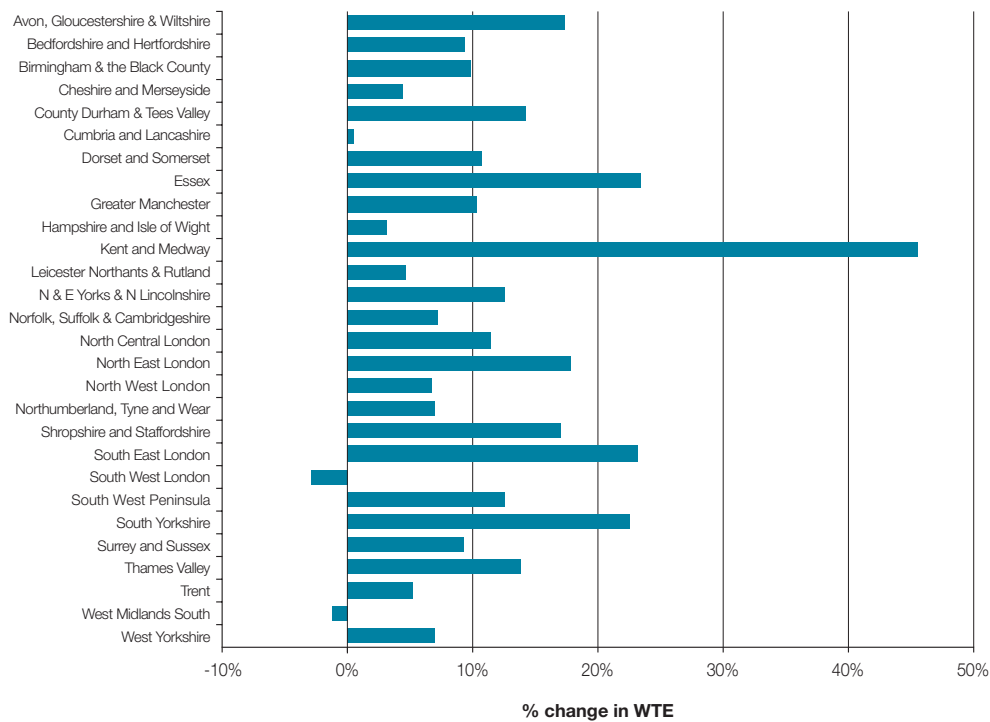
- This represented an 11% increase on the 8,892 WTE staff reported in 2004 and an overall 27% increase on the 7761 WTE staff reported in 2003 indicating that the PSA target of 10% annual growth of in CAMHS staff numbers was not only achieved in the three years 2003 to 2005 but exceeded.
- Linked to the population of children and young people, there was an average of 89.1 WTE CAMHS staff per 100k population of 0-17 year olds in 2005. This had risen from an average of 80.4 WTE per 100k in 2004.
- The workforce was very unevenly distributed across the country. Local variation across SHAs ranges from 47.7 WTE per 100k to 217.6 WTE per 100k (Map 5.1).

Map 5.1: 2005 workforce per 100k population aged 0-17 year olds



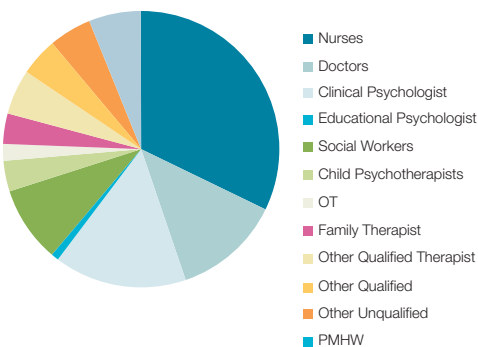
Changes in the workforce were also unevenly distributed. Within SHA areas, these ranged from an increase of 46% to two areas where overall decreases in workforce were reported (Fig. 5.1).

Fig. 5.1: Change in 2005 workforce as a percentage of 2004 workforce



5.2 Professionals in the CAMHS workforce

Fig. 5.2: Total workforce by profession, 2005



In order to meet the diverse needs of children and young people, the CAMHS workforce is multi-professional with a range of specialists. The largest professional group was nurses making up 26% of the workforce in 2005 (28% in 2004). The other main professional groups were doctors (10% in 2005 and 11% in 2004), clinical psychologists (13% in 2005 and 14% in 2003), and administrators (16% in both 2005 and 2004) (Fig. 5.2).

Family therapists were mapped separately for the first time in 2005, and accounted for 3% of the total workforce. As a result, the number of other qualified therapists showed a reduction of 14% in 2005 from the previous year – a drop from 6% of the workforce in 2004 to 5% in 2005 (Table 5.2).

Other trends in the professional make-up of the CAMHS workforce reported in 2005 included:

- Other unqualified staff increased by 80% from 219 in 2004 to 394 in 2005, but they remained just 4% of the total workforce.
- Managers increased by 41% between 2004 and 2005 but this was only from 160 WTE to 227 WTE. These numbers were relatively low for the number of teams reported because few managers were in full-time management posts and their clinical time was mapped under their professional contribution.
- Important increases were recorded in the number of other qualified workers who increased by 38% and primary mental health workers (PMHWs) who increased by 33%.
- The psychology and medical workforce showed minimal change - there were 10.5 WTE more doctors and 0.21 WTE less psychologists mapped in 2005 as compare with 2004.
- Primary Mental Health Workers were mapped for the first time in 2004 and their numbers grew by 33% from 362 WTE in 2004 to 506 WTE in 2005. In the 2003 exercise PMHWs may have been mapped against other core professions.
- The social worker workforce increased by 13% from 640 in 2004 and to 722 in 2005.

Table 5.2: Change in professional group make up of CAMHS staff, 2004-05 %

Professional group	2004	2005	change %
Other unqualified staff	219.0	393.8	80%
Manager	160.9	227.3	41%
Other qualified staff	253.9	351.5	38%
Primary mental health worker	381.7	505.8	33%
Social worker	639.9	722.1	13%
Admin	1393.5	1551.7	11%
Occupational therapist	165.1	175.5	6%
Nurse	2517.3	2599.5	3%
Doctor	1008.3	1018.8	1%
Psychologist	1319.8	1319.6	0%
Child psychotherapist	312.2	289.0	-7%
Other qualified therapist	522.0	446.7	-14%
Family Therapist		274.0	
TOTAL STAFF	8893.6	9875.7	11%

5.3 Workforce in local and wider teams

Definitions

Local teams:

A local team is one that has been commissioned to serve a defined local area. These are usually made up of a single, or small number of PCTs and/or local authorities. Almost all children and young people using a local team will come from this area but it is acknowledged that local teams will also occasionally support clients from further afield.

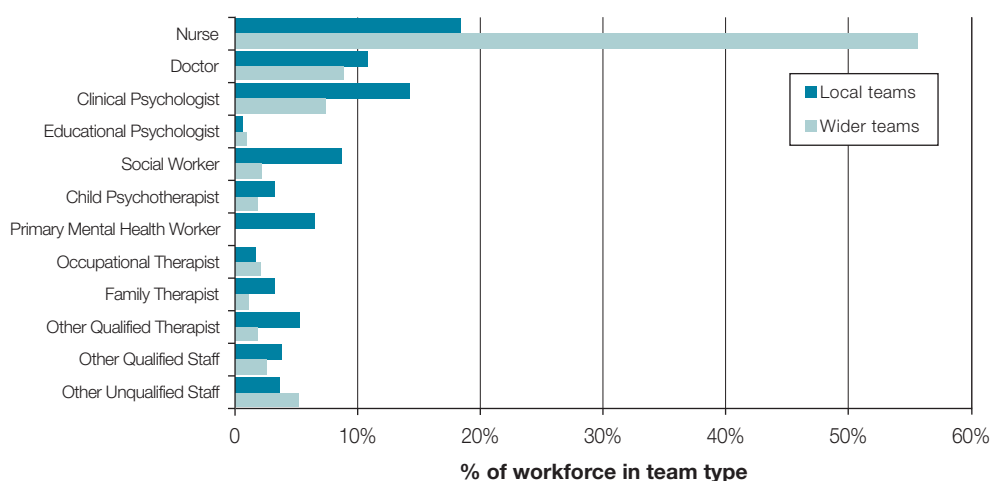
Wider than local teams

A wider than local team will have commissioning arrangements to serve an area best described in terms of Strategic Health Authorities (SHAs). These can be national services providing specialist provision for the whole of England.

In CAMHS mapping, a distinction has been made between local and wider teams (see definitions). These categories are particularly useful with reference to workforce as they can be used to distinguish staff that work in teams providing for a local defined population from those that work in teams which serve larger catchment areas, such as a number of SHAs or regions. For wider teams, no population can be identified with any accuracy and therefore it is not possible to map workforce to population.

As wider than local teams tend to be tier 4, there were key differences in the staffing of local and wider teams. This was particularly evident with respect to nurses, who dominated the staffing of wider teams (56%) (Fig. 5.3). In order to explore these differences, local and wider team workforces will be examined in turn.

Fig. 5.3: Percentage of workforce in local and wider teams by profession

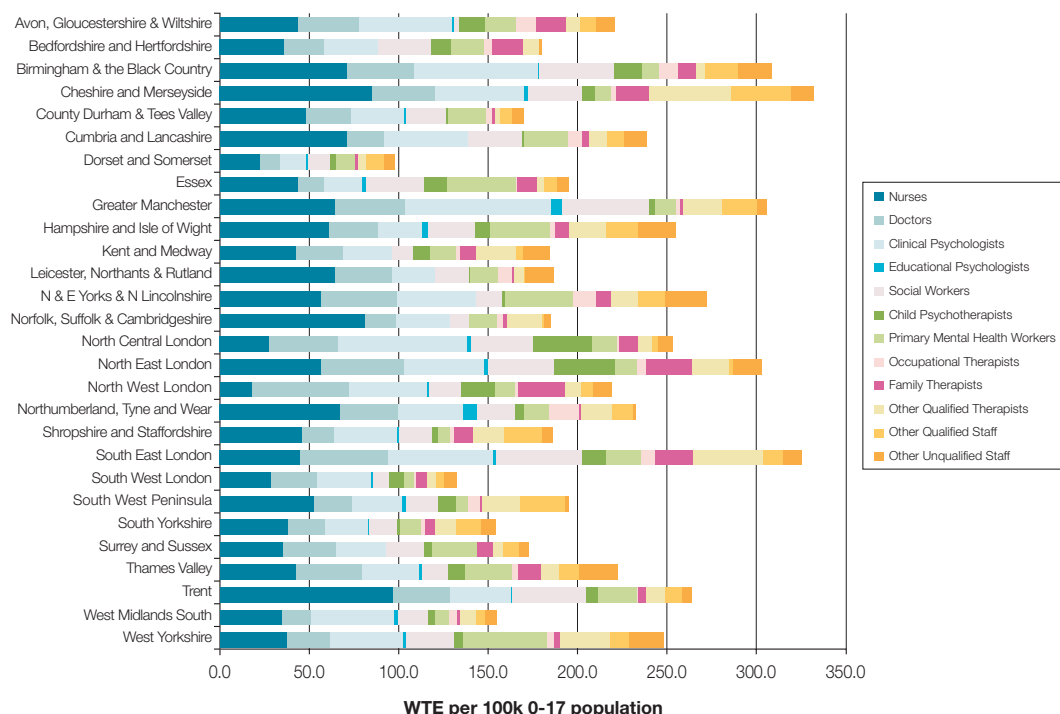


5.4 Workforce patterns within local teams

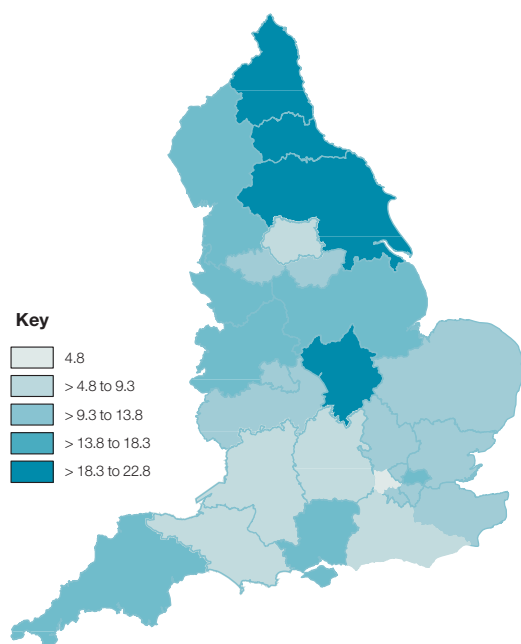
Staff employed in local teams accounted for 79% of the CAMHS workforce, an increase from 76% of the workforce in 2004. In total, 7,753 WTE staff were employed in local teams distributed as follows:

- Nurses made up 18% of the local team workforce but there was considerable variation nationally (see Map 5.4a). On average there were 13 WTE nurses per 100k population (aged 0-17) but the variation in SHA ranged from 20 to 9 nurses per 100k (aged 0-17) population aged 0-17 (Fig. 5.4).
- Clinical psychologists made up the next largest professional staff group in local CAMHS teams providing 14% of the workforce. Overall there were 10 WTE clinical psychologists per 100k population but this ranged from 6 to 15 in SHA areas. The very patchy national provision is shown in Map 5.4c.
- Doctors made up 11% of the local team workforce with 832 WTE in total. Provision varied from 6 to 13 per 100k population (aged 0-17). On average there were 8 doctors per 100k population with the highest provision overall in London (Map 5.4b).
- The social work workforce was considerably smaller at 675 (aged 0-17) WTE. This was 9% of the total staffing of CAMHS local teams. There was a national average of 6 WTE social workers per 100k population, ranging from 3 to 9.
- The provision of child psychotherapists showed considerable SHA variation. On average there were 2 WTE child psychotherapists per 100k (aged 0-17) population but provision was concentrated in London and the south (Map 5.4d).
- In total 502 WTE PMHWs were reported in local CAMHS teams. PMHW were the fifth largest professional staff group in local teams, accounting for 7% of the workforce. Overall there were 5 WTE PMHWs per 100k population, ranging from 1 to 11 in SHA area (Map 5.4e).

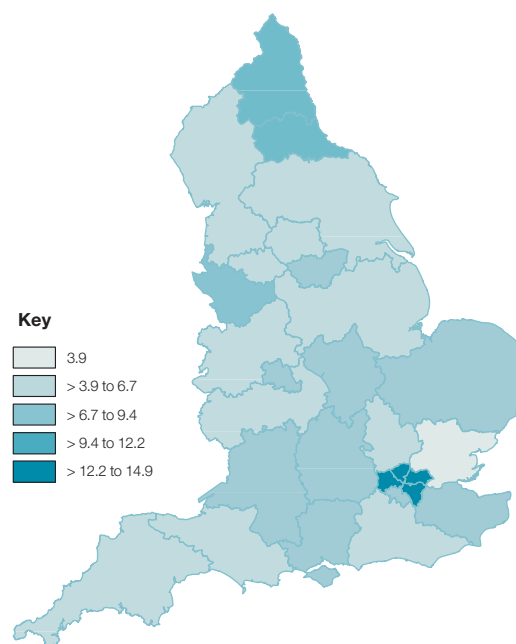
Fig. 5.4: Local teams - staff per 100k 0-17 population by profession



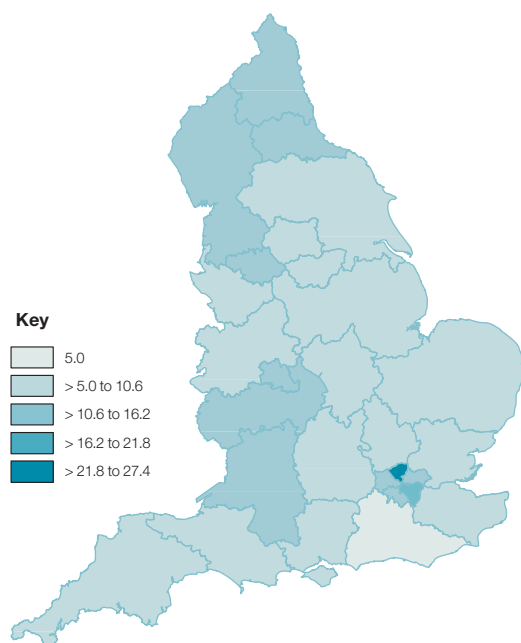
**Map 5.4a: Nurses per 100k (0-17)
population in local teams**



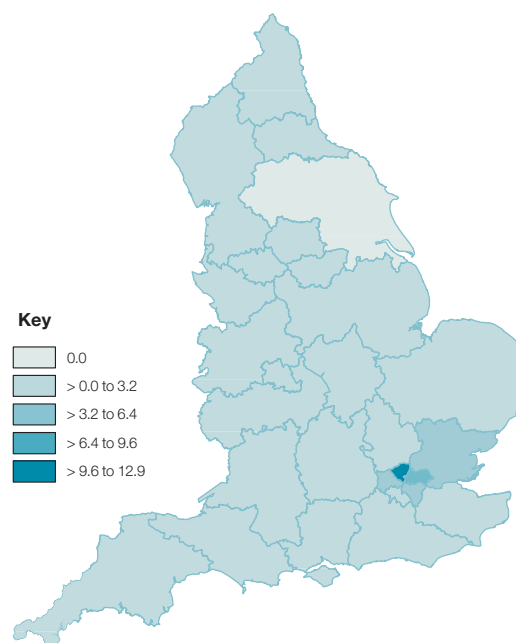
**Map 5.4b: Doctors per 100k (0-17)
population in local teams**



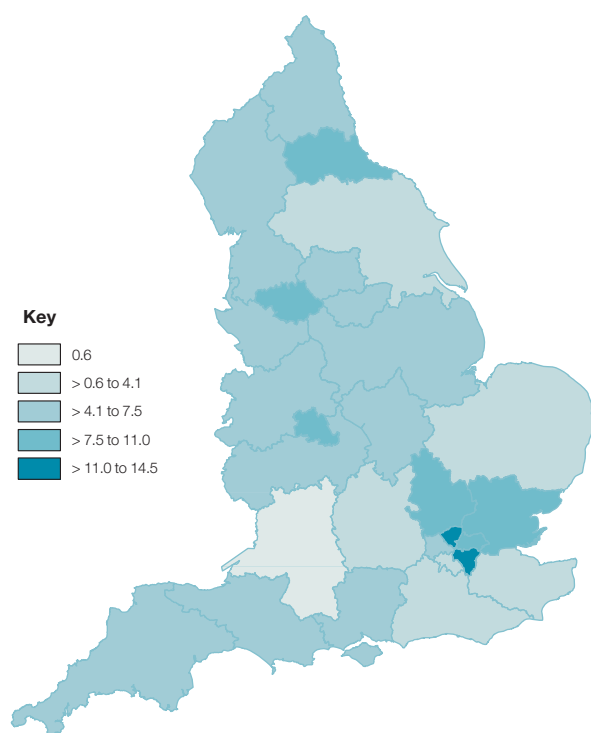
**Map 5.4c: Clinical psychologists per 100k (0-17)
population in local teams**



**Map 5.4d: Child psychotherapists per 100k (0-17)
population in local teams**



Map 5.4e: Primary Mental Health Workers per (0-17) 100k population in local teams

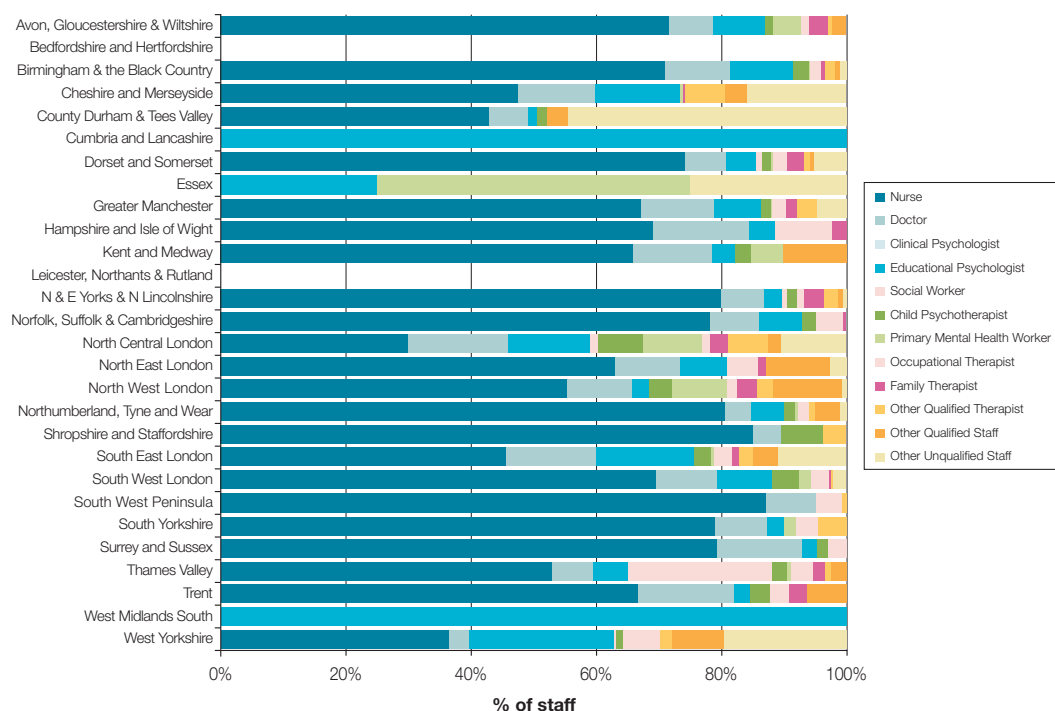


5.5 Workforce patterns in teams delivering a service to a wider area

The majority of wider than local teams are small specialist units delivering tier 4 services. Owing to the specialist nature of the provision, wide variations were seen in the staff employed. Staffing levels within wider than local teams have stayed almost unchanged since 2004. 2,123 WTE staff (21%) of the CAMHS workforce was employed in wider than local teams in 2005, compared with 2,116 WTE in 2004. The proportion of wider than local staff has dropped from 24% to 21% of the total CAMHS workforce. The variation across the country was very marked (Fig. 5.5).

As staffing of wider than local teams cannot be examined against specified populations, the professional make-up of the workforce has been examined in terms of percentages of total staffing. Overall, 56% of the workforce was nurses, reflecting the dominance of inpatient provision. Doctors made up 9% of the workforce, clinical psychologists 7%, educational psychologists 1% and child psychotherapists 2%. Social workers were just 2% of the staff group.

Fig. 5.5: Workforce in wider teams



5.6 Specialist CAMHS (Tiers 2-4) support to tier 1

Definitions

PMHW:

Primary Mental Health Workers (PMHW) are specialist child and adolescent mental health workers, providing an early intervention interface between tier 1 and specialist CAMHS. They also work on the promotion of mental health in children and provide direct intervention with children, young people and families, usually working jointly with tier 1 professionals.

Support to tier 1:

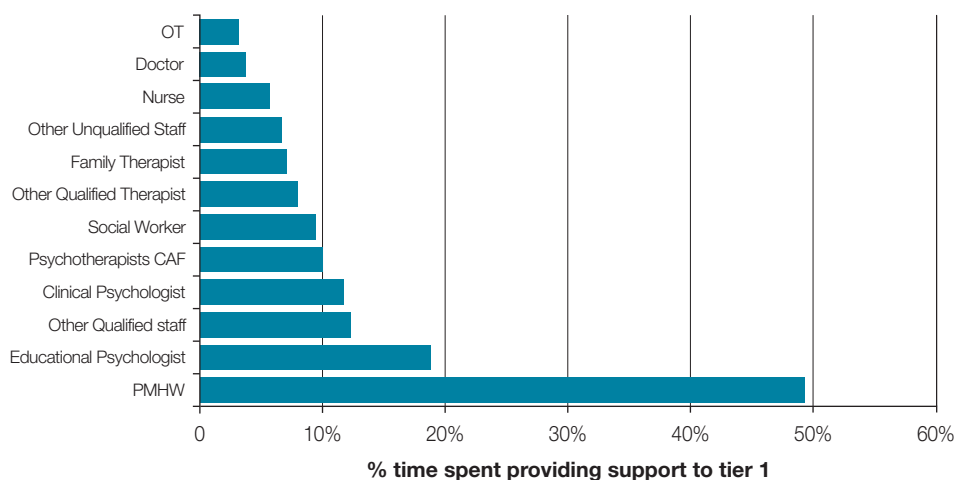
All staff were asked to record time spent in working with tier 1. This includes workers providing a combination of support, advice, consultation, supervision and training to tier 1 professionals on emerging mental health needs in children and young people.

Support to tier 1 CAMHS work was investigated in the mapping in two ways. Firstly through the work of primary mental health workers (PMHW) and secondly by asking all clinical staff to estimate the time that they spent supporting tier 1 work.

2005 was the second year that PMHWs were identified as a professional group in the CAMHS mapping exercise. The number of these workers was found to have grown from 382 WTE in 2004 to 506 WTE in 2005, an increase of 33%.

The time spent by clinical staff in supporting tier 1 also rose from 9% in 2004 to 11% in 2005. Fig. 5.6a shows which professional groups this support came from. Overall clinical psychologists spent 11.7% of their time supporting tier 1 staff, nurses 5.6% of their time, social workers 9.3% and doctors 3.9%. Educational psychologists recorded 18.8% of their time spent supporting tier 1 and child psychotherapists 10.0%.

Fig. 5.6a: Time spent by clinical staff supporting tier 1 work



5.7 Care staff

Care staff are defined as all qualified and unqualified staff in post, excluding admin and managers. The CNSF sets out guidelines for levels of staffing in tier 3 CAMHS provision. These propose that generic specialist multi-disciplinary CAMHS at tier 3 with teaching responsibilities and providing evidence-based interventions for 0-17 year olds would need a minimum of 20 WTE care staff per 100,000 total population, and a non-teaching service, a minimum of 15 WTE care staff. However, it is acknowledged that it is not straightforward to estimate the numbers of care staff needed for viable multi-disciplinary teams at tier 3 that meet local demands and provide a sustainable service as much depends on the local demography, demand and the range of services available within the area.

In the mapping no data is specifically collected on tier 3 services as the 2002 CAMHS mapping pilot study found that teams operated across tiers and within broad team types. Therefore local teams have been used as a proxy for tier 3 services as many of them deliver elements of tier 3 and they all deliver to a defined local population.

Counting care staff only, the number of staff within local CAMHS teams increased from 10.2 WTE per 100k population in 2004 to 11.7 WTE per 100k population in 2005. There were large variations by SHA, ranging from 20.7 WTE to 6.0 WTE (Table 5.7). In total, there were 6,221 WTE care staff reported in 932 local teams, an average of 7 clinical staff per local team.

Table 5.7: Care staff in local teams per 100k total population for comparison with CNSF estimate of tier 3 requirements

Strategic Health Authority	Care staff per 100k population in local teams
Avon, Gloucestershire & Wiltshire	9.8
Bedfordshire and Hertfordshire	9.8
Birmingham & the Black Country	13.1
Cheshire and Merseyside	13.6
County Durham & Tees Valley	13.3
Cumbria and Lancashire	11.2
Dorset and Somerset	7.5
Essex	10.7
Greater Manchester	11.6
Hampshire and Isle of Wight	12.7
Kent and Medway	10.8
Leicester, Northants & Rutland	11.2
Norfolk, Suffolk & Cambridgeshire	11.2
N & E Yorkshire & N Lincolnshire	9.5
North Central London	20.3
North East London	19.1
North West London	11.9
Northumberland, Tyne and Wear	15.8
Shropshire and Staffordshire	12.1
South East London	20.7
South West London	9.9
South West Peninsula	11.9
South Yorkshire	10.9
Surrey and Sussex	6.0
Thames Valley	10.0
Trent	9.3
West Midlands South	9.8
West Yorkshire	9.4
Total	11.7

5.8 National vacancy rates

Definition

Vacancy:

A vacancy is a funded post which a service is actively seeking to fill.

After reporting high vacancy rates in the CAMHS workforce in 2004, a much improved situation was recorded in 2005. The number of funded vacancies dropped from 1,490 in 2004 to 1,045 in 2005, a reduction of 30% (Table 5.8). In this 12 month period, the number of funded posts in CAMHS teams rose by only 5% but due to successful recruitment, the CAMHS workforce was able to increase by 11%. Vacancy rates were reduced from 14% of funded establishment in 2004 to 10% in 2005.

Table 5.8: Trends in CAMHS staffing and vacancy rates 2004 and 2005

	2004	2005	Difference	%
Total staff in post (WTE)	8893.67	9875.69	982.02	11%
Total funded vacancies (WTE)	1490.35	1045.21	-445.14	-30%
Funded establishment (WTE)	10384.02	10920.90	536.88	5%
Vacancies as % staff in post	17%	11%		
Vacancies as % funded establishment	14%	10%		

Considerable variation was found in the vacancy rates of specific professional groupings (Fig. 5.8a). Occupational therapists had the highest vacancy rate (15%), but this was down from 17% in 2004. Vacancy rates for PMHWs were also high at 14%, down from 19% in 2004.

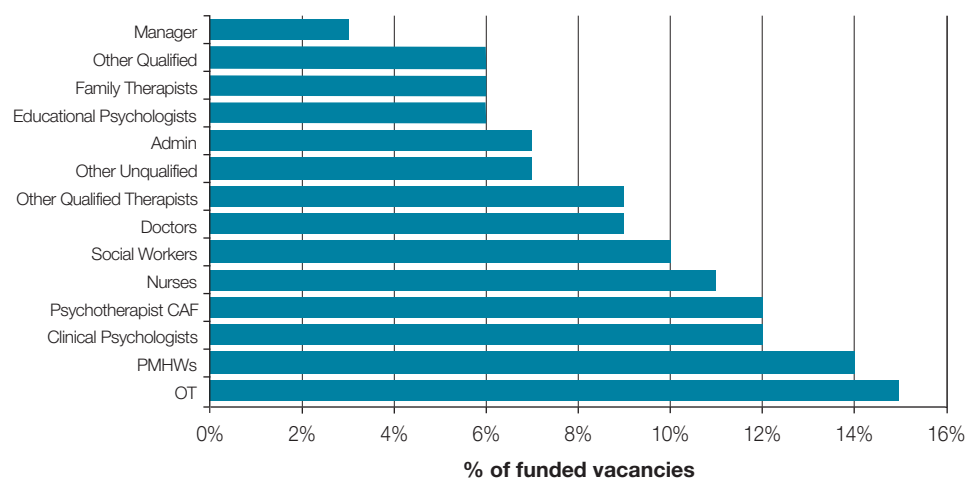
Nurses and clinical psychologists both reported a vacancy rate of 15% in 2004 but this has reduced to 11% for nurses and 12% for clinical psychologists by 2005. Very different patterns of vacancies were reported around the country (Fig. 5.8c and e).

Considerable success in the recruitment of doctors was reported with their vacancy rate falling from 13% in 2004 to 9% in 2005. However, SHA vacancy rates for CAMHS doctors ranged from 0 to over 30% (Fig. 5.8d).

Social workers also showed a reasonable improvement in recruitment with vacancy rates reducing from 15% in 2004 to 10% in 2005 and services reporting no vacant social work posts in as many as 4 SHA areas (Fig. 5.8f).

Managers had the lowest vacancy rates of just 3%, down from 9% in 2004 while administration vacancy rates had decreased only slightly from 9% on 2004 to 7% in 2005.

Fig. 5.8a: Funded vacancy rates in the CAMHS workforce in 2005 by profession



Psychotherapists reported the only increase in vacancy rates for the 12 months 2004 to 2005 with the rate rising from 11% to 12%. The vacancy rate for other qualified therapists went down during the same period from 13% to 9%. It was too soon to record trends in family therapy vacancy rates as this was the first year of data collection. Their vacancy rate was 6%.

Strong regional variation was apparent in the overall vacancy rate of staff (Fig. 5.8b).

Fig. 5.8b: Vacancy rate - all staff

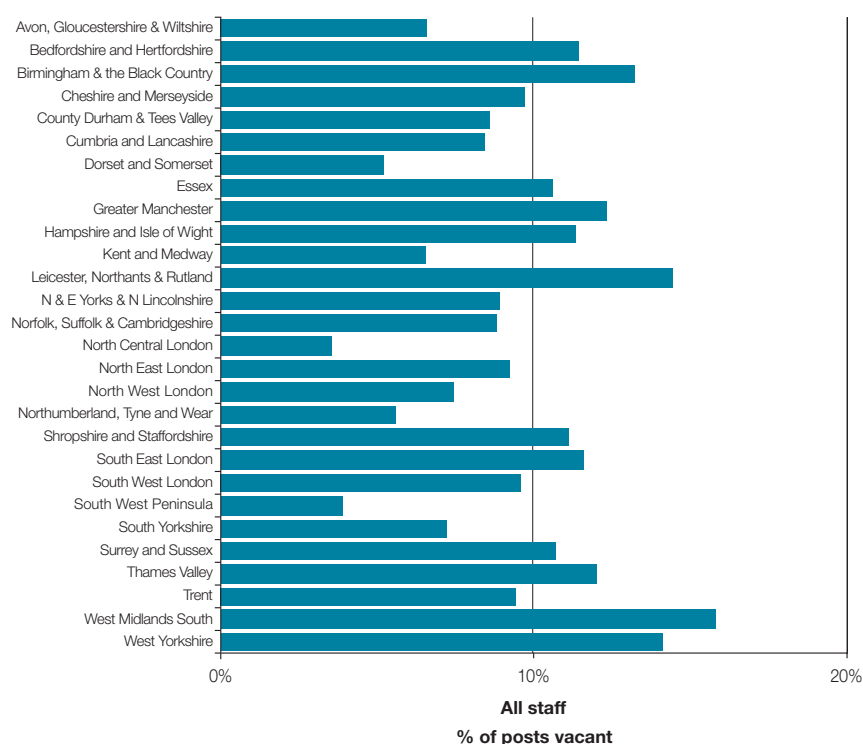


Fig. 5.8c: Vacancy rate - nurses

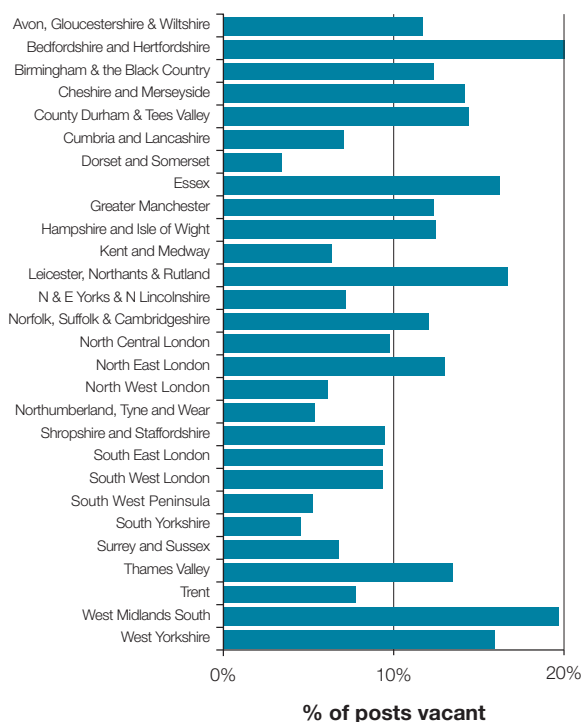


Fig. 5.8d: Vacancy rate - doctors

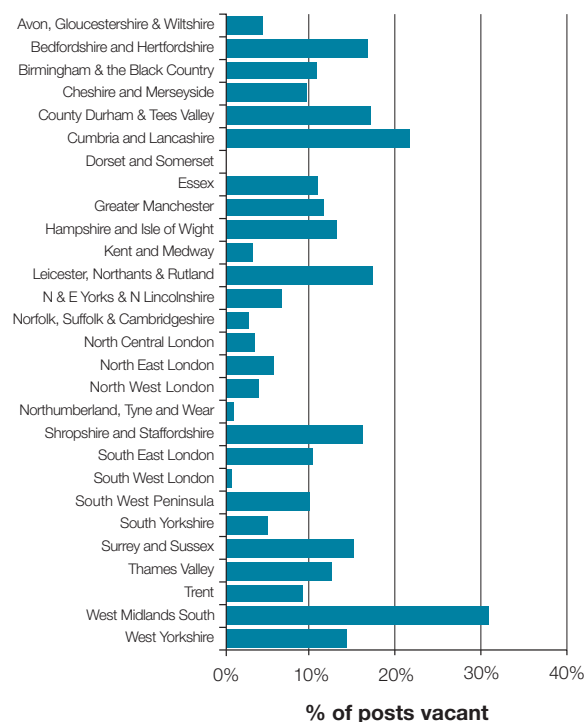


Fig. 5.8e: Vacancy rate - clinical psychologists

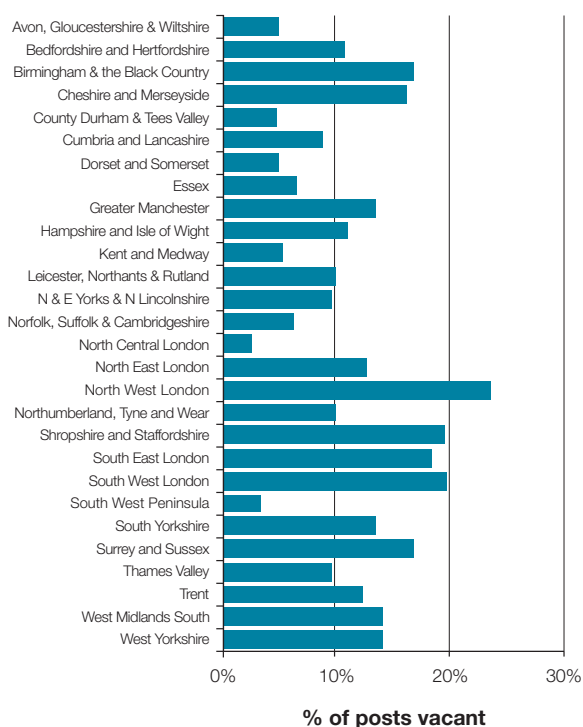
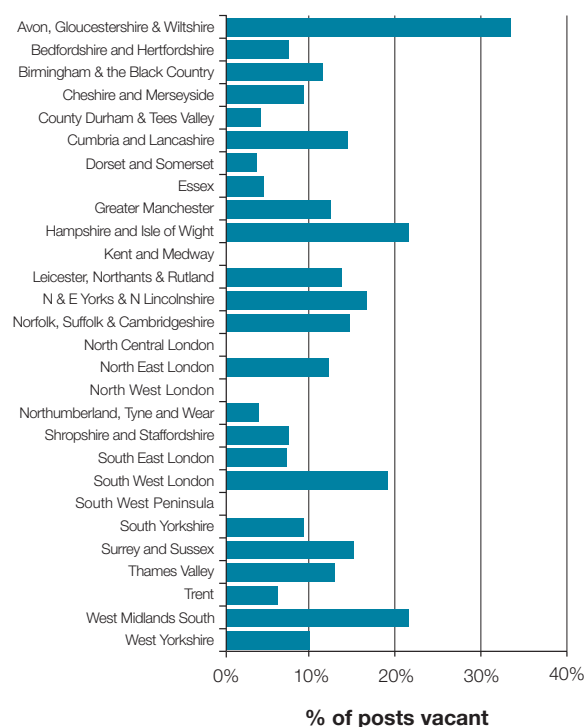


Fig. 5.8f: Vacancy - social workers



Chapter 6:

Technical notes

It covers:

- | | |
|-----|---|
| 6.1 | Basic mapping concepts |
| 6.2 | Brief description of collection process |
| 6.3 | Changes from 2004 |
| 6.4 | Checks and reliability |
| 6.5 | Relationship to performance monitoring |



6.1 Basic mapping concepts

Key characteristics of CAMHS mapping include:

- Annual data collection
- A 'service' (CAMHS NHS provider) as the unit of data collection
- Services cover a defined geographical area for local provision, usually individual or groups of PCTs or local authorities
- Includes specialist CAMHS only, covering tier 2 to 4 provision
- Includes all relevant CAMHS provider agencies to reflect local partnerships
- Describes services in terms of 'teams', or units of service delivery
- Separate data collection for expenditure on CAMHS
- All data publicly available through the internet.

6.2 Brief description of data collection process

- Introductory roadshow and telephone/email helpdesk provided throughout collection period
- CAMHS and commissioners identified by Strategic Health Authorities
- Local head of service nominated for each 'service' to take responsibility for data returns
- Local head of services reviews data submitted in previous year, revising the list of teams as required
- Head of service either completes team data or 'delegates' completion to the team manager
- Commissioning lead completes commissioning data
- Data are collected on-line through the Internet
- Data are checked and confirmed correct by chief executives
- Data are frozen on 28th February 2006 - no further changes accepted.

6.3 Changes to the exercise:

The mapping exercise is kept, as far as possible, as similar to the previous year's data collection. However, the changes below were put in place to improve the quality, policy relevance and consistency of the data collected.

6.3.1: Changes from 2004

- Dropped workforce grading and move to broad professional workforce categories due to the partial implementation of Agenda for Change. Workforce grades will be reintroduced in the 2006 mapping exercise
- Moved from service delegation to commissioners to a specific log in for each commissioning organisation
- Strengthened guidance for the inclusion of consultation within caseload
- Added local authority questions linked to performance indicators carried out by the Commission for Social Care Inspection.

6.3.2: Changes from 2003

- Individual staff questionnaires dropped
- Commissioners reported and signed-off investment data directly
- Previous years data presented as a starting point
- Entry of detailed data delegated to team managers and commissioners
- Caseload data collected for teams not individual staff
- New question indicating whether teams appearing for the first time were new or just previously unmapped.

6.4 Checks and reliability

- Summary reports automatically screens data for completeness and plausibility
- Standardised codes and selection from pre-defined lists wherever possible
- Summaries giving overall view of the data entered signed off by local chief executives
- Data scrutinised by Durham Team during preparation of atlas and performance indicator tables; problems checked with local informants.

6.5 Relationship to performance indicators

An important aspect but not the whole purpose of the mapping.

6.5.1: Healthcare commission performance indicators

Key data source for three indicators

- Increased staff
- Increased investment
- Increased activity.
- Healthcare commission data frozen at the 28th February –subsequent data cleaning done for Atlas.

6.5.2: Commission for Social Care Inspection (CSCI) performance indicators

- Source of data for PAF A70
- CSCI data frozen at the 28th February –subsequent data cleaning done for Atlas.

Annex 1:

Tiers 1, 2, 3 and 4

Mental health services for children and adolescents have been described according to a four-tier framework.



Tier 1

The phrase primary care is used to describe agencies that offer first-line services to the public and with whom they make direct contact.

This includes interventions by:

- GPs
- Health visitors
- Residential social workers
- Family aides, carers and support workers offer various types of assistance that help to prevent family breakdown.
- School nurses
- Teachers
- Juvenile justice workers

Family aides, carers and support workers offer various types of assistance that help to prevent family breakdown. All of these primary care workers regularly encounter early manifestations of difficulty, problems and disorder in children. Complex and serious problems require immediate referral to tier 2 or 3 (specialist) level of CAMHS. The bulk of more minor problems is, and should be, handled within the primary care sector through discussion, and counselling.

Role of **Primary Mental Health Workers (PMHWs)**: PMHWs are tasked with supporting and enabling tier 1 professionals and improving the links between the primary and specialist tiers of service. These professionals would need to be integrated into a specialist community CAMHS.

The roles of PMHWs include:

- identifying mental health problems early in their development – early intervention
- offering general advice – and, in certain cases, treatment for less severe mental health problems
- pursuing opportunities for promoting mental health and preventing mental health problems.

Tier 2

A level of service provided by professionals working on their own who relate to others through a network rather than within a team:

- Clinical child psychologists
- Educational psychologists
- Paediatricians – especially community
- Community child psychiatric nurses or nurse specialists
- Child psychiatrists.

Tier 2 services offer:

- training and consultation to other professionals (who might be within tier 1)
- consultation for professionals and families
- outreach to identify severe or complex needs where children or families are unwilling to use specialist services
- assessment which may trigger treatment at this level or in a different tier.

The purpose of tier 2 services is to:

- enable families to function in a less distressed manner
- enable children and young people to overcome their mental health problems
- diagnose and treat disorders of mental health
- enable children and young people to benefit from their home, community and education
- enable children, young people and their families to cope more effectively with their life experiences.

Tier 3

A specialist service for the more severe, complex and persistent disorders. Because of the complexity of the work that they undertake, staff usually work in a multi-disciplinary team or service working in a community child mental health clinic or child psychiatry outpatient service. Tier 3 services might have input from the following professionals:

- Social workers
- Clinical psychologists
- Community psychiatric nurses
- Child and adolescent psychiatrists
- Art, music and drama therapists
- Child psychotherapists
- Occupational therapists.

In addition to those of tier 2, the tasks of tier 3 services are:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in tier 2 because of the complexity, risk, persistence and interference with social functioning and normal development, and the consequent need for specialist skills
- To act as gatekeepers, with clearly agreed criteria, for the assessment for referrals to tier 4
- To have relationships which ease the passage of children and young people into such care
- To contribute to the services, consultation and training at tiers 1 and 2
- To ensure smooth transition of individual cases or families to tiers 2 and 1 before completion of the involvement of tier 3 service
- To participate in research and development projects.

Tier 4

Tier 4 should be seen as part of a continuum of care for clients and families. They are essentially tertiary services such as day units, highly specialised outpatient teams, and inpatient units for older children and adolescents who are severely mentally ill or at suicidal risk.

Tasks undertaken in tier 4 involve:

- The assessment, treatment and management of children, adolescents and their families whose mental health problems and disorders cannot be managed in tier 3 because of their complexity, risk, persistence and interference with social functioning and normal development, consequently requiring very specialised skills.
- Provisions of interventions that require such a level of skill
- Provision of services that would not be cost effective in every locality because of sporadic demands for them in smaller populations
- Provide support to staff working in tiers 1, 2 and 3, where they are engaged in complex cases that might otherwise require management in tier 4.

Sources:

Health Advisory Service (1995) Together we stand. London: HMSO

Audit Commission (1999) Children in Mind. London: Audit Commission.

Annex 2:

Rating scale for CAMHS Local Authority PI CF/A70



In August 2005 CSCI notified Councils with Social Services Responsibilities that a new PI relating to CAMHS would be included in the 2005-06 PI set.

The notification stated :

The final definition of the PI will be agreed between CSCI, DfES and DH in summer 2005 and will be collected via NHS returns to Strategic Health Authorities or to the Durham University CAMHS mapping team. The PI will cover answers to the following:

1. Was a full range of CAMHS for children and young people with learning disabilities commissioned for your council area?
2. Did 16 and 17 year olds from your council area who require mental health services have access to services appropriate to their age and level of maturity?
3. Were arrangements in place for your council area to ensure that 24 hour cover is available to meet urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated?
4. Were protocols in place for your council area for partnership working between agencies for children and young people with complex, persistent and severe behavioural and mental health needs.

Rather than having an open and closed answer 'yes' / 'no' to each of the four elements of the PI, there may be a rating for each measure above and a scoring system which allocates points towards an overall PI more appropriately.

The new PI reflects development in local authority areas of key services for children and adolescents. It has four components, the first three of which relate to a PSA target on CAMHS. The scoring used is broadly in line with the Self-Assessment matrix for 2005-06 – each of the components features in this matrix¹. The plans and protocols for each component must be part of the overall strategy for the CAMHS service developed for each CAMHS partnership in line with the NSF.

Councils are to report their self assessed score on each of the four components via the Durham CAMHS mapping website (<http://www.camhsmapping.org.uk/2005/index.php>) by 31.01.06. The registration process to submit data is accessible via indicating 'LA commissioner' on the web-page <http://www.camhsmapping.org.uk/2005/registration.php> and choosing your council name on the following screen.

The responses are to relate to the position across the local authority (where there may be more than one CAMHS partnership) as at that date.

Helpdesk support is available from 0191 334 1489. This number will be manned from 9.30 to 4.30 weekdays with a finish at 1.00pm on Wednesdays. Outside these hours an answer machine will operate. Alternatively email service.mapping@durham.ac.uk

¹ See CAMHS Partnership self assessment matrix 2005-06 (<http://www.hascas.org.uk/camhs/partnership.htm>)

Component 1 : in 6 : Multi agency provision of specialist services (item viii) and 9 Accessibility (item vi)

Component 2 : in 6 : Multi agency provision of specialist services and 9 Accessibility (item v)

Component 3 : in 5 : Multi agency provision of targeted services (item vi) and 9 Accessibility

Component 4 : in 5 : Multi agency provision of specialist services (item xv) and 9 Accessibility

All four components should be set within a local plan developed in partnership and reflecting needs assessment (in 2 : Strategy) and workforce issues (in 7: Workforce)

Component 1:

At January 31 2006, has a full range of CAMHS for children and young people with learning disabilities been commissioned for the council area?

Detailed Definition

Partnership working and protocols are in place to ensure that co-ordinated and integrated packages of care are available for children and young people to meet their health, education and social needs. Including links between CAMHS and other services for children with learning disabilities including special educational needs services, paediatrics and children with disability services.

Services should be provided by staff who have the necessary training and competencies to deal with children with learning difficulties and mental health needs.

- Children and young people with learning disabilities should receive equal access to CAMHS, including:
- Mental health promotion and early intervention (including attention to attachment and parenting issues);
- Training and support to front-line professionals, in particular in the recognition of normal development and developmental delay;
- Adequately resourced tiers 2 and 3 learning disability specialist CAMHS with staff with the necessary competencies to address mental health difficulties in children and young people with learning disabilities or pervasive developmental disorders; and
- Access to tier 4 services providing in-patient, day-patient and outreach units for children and adolescents with learning disabilities and severe and complex neuro-psychiatric symptomatology.

Commissioners ensure that joint agency planning and commissioning takes place between health, children's services (including social care and education) and the voluntary sector for children and adolescence with learning disabilities who have severe, enduring and complex needs.

Rating for Component 1 as at 31 January 2006

- 1: None of the above in place OR Strategic plans for the council area have yet to address the needs of children and young people with learning disabilities and mental health needs.**
- 2: Plans and protocols for children and young people with learning disabilities and mental health needs are in place: services have yet to be put in place.**
- 3: Plans and protocols for children and young people with learning disabilities and mental health needs are in place: some services are in place, some are still to be developed so as to provide cover across the whole council area.**
- 4: A fully comprehensive CAMHS for children with learning disabilities and mental health needs is available, including fully implemented protocols between services and appropriately trained staff, covering the whole council area.**

Component 2:

As at January 31 2006, do 16 and 17 year olds from the council area who require mental health services have access to services appropriate to their age and level of maturity?

Detailed Definition

The availability of the full range of CAMHS for 16 and 17 year olds. [NB: this does not mean that these services need to be provided under the auspices of CAMHS in all cases. There may be cases where adolescents prefer to be treated in an adult mental health environment. The provision of CAMHS and, in particular, the interface with adult mental health services should be sufficiently flexible to allow patient choice to be taken into account in determining the most appropriate delivery of assessment and treatment.]

The following aspects of service need to be in place for a positive response to be given to this question:

- Young people under eighteen years of age are provided with services which meet their developmental needs.
- Local agreements are in place for handling referrals of young people to ensure that there are no gaps in service provision and that there is scope for choice and flexibility.
- Written protocols are in place and implemented with PCTs and provider trusts to ensure that young people experience a smooth transition of care between child and adult services.
- Services ensure that attention is paid to the child protection needs (in line with ACPC policies) and the dignity and safety of young people cared for in adult psychiatric beds.
- CAMHS and adult mental health services collaborate to develop early intervention teams for young people with early onset psychosis.
- The Care Programme Approach is used when young people are discharged from in-patient care and on transition from child and adolescent to adult services.

Rating for Component 2 as at January 31 2006

- 1: None of the above are in place OR Strategic plans for the council area have yet to address the needs of 16 and 17 year olds who require mental health services.**
- 2: Plans and protocols for 16 and 17 year olds who require mental health services are in place: services have yet to be put in place.**
- 3: Plans and protocols for 16 and 17 year olds who require mental health services are in place: some services are in place, some are still to be developed so as to provide cover across the whole council area.**
- 4: A fully comprehensive CAMHS for 16 and 17 year olds who require mental health services is available, including fully implemented protocols between services and appropriately trained staff, covering the whole council area.**

Component 3:

As at 31 January 2006, are arrangements in place for the council area to ensure that 24 hour cover is available to meet urgent mental health needs of children and young people and for a specialist mental health assessment to be undertaken within 24 hours or the next working day where indicated?

Detailed Definition

Local authorities with Primary Care Trusts ensure that policies and protocols for the management of children and young people with emergency* mental health needs are developed in partnership. This includes:

- The availability of 24 hour / seven days a week cover to meet urgent needs (see * below for definition of urgent needs), and to undertake a specialist mental health assessment within 24 hours or by the end of the next working day. [NB There will be a variety of ways of providing this provision. In most cases it will involve informing possible referral points such as A&E Departments, GP out of hours services, police, etc, of appropriate contact information for on-call CAMHS specialist staff.]
- **Note:** *An on-call service is a 24/7 response provided by either a dedicated staff team working on a rota basis or by an out-of-hours service which works in tandem with a service providing an emergency same-day response within office hours.*

* All staff who are involved in providing these services receive specific training for this purpose.

Children and young people presenting as emergencies or as requiring urgent assessment and intervention include those who have rapidly developed a serious or life-threatening condition, for example, a young person who is psychotic or suicidal; those whose needs have become urgent as a consequence of the more routine services being unavailable to them in a timely way; and those about whom adults are urgently seeking reassurance and support.

Rating for Component 3 as at January 31 2006

1: Strategic plans for the council area have yet to address the needs for 24 hour / 7 days per week access for emergencies and/or for specialist mental health assessment within 24 hours.

2: Protocols and plans are in place : services have yet to be put in place.

3: Protocols and plans are in place but are only partially implemented.

(i.e. Specialist CAMHS providers within the council area, between them, include on-call provision to cover emergencies in local children and young people [this may be provided by just one agency] OR An emergency service is provided which will see children by the end of the next working day).

4: Protocols and plans are in place and are fully implemented.

(i.e. specialist CAMHS workers are on call and offer next day follow up. Specialist CAMHS providers within the council area, between them, include on-call provision to cover emergencies in local children and young people (this may be provided by just one agency). The on-call is provided exclusively by CAMHS professionals.)

Component 4:

At January 31 2006, are protocols in place for the council area for partnership working between agencies for children and young people with complex, persistent and severe behavioural and mental health needs?

Detailed Definition

Agreements for those with complex, persistent and severe behavioural and mental health needs are in place between health, children's services (education and social care) and youth justice which may be organised across several PCT/LA boundaries for:

- Joint funding
- Assessment
- Provision of services, including specialist residential or foster care for the above young people.

Contingency arrangements have been agreed at senior officer level between health and children's services (education and social care) to meet the needs and manage associated risks for this group of young people.

Rating for component 4 as at January 31 2006

- 1: No protocols or partnership services are in place for children and young people with complex, persistent and severe behavioural and mental health needs.**
- 2: Protocols and plans at an early stage of development: agreed access arrangements are not yet operating.**
- 3: Protocols and plans are in place: access arrangements are operating but not across the whole council area.**
- 4: Protocols and plans are in place : access arrangements for services are fully operational.**

Verification of scores submitted by councils

PCTs are reporting via the LDPR on the first 3 components of this PI to SHAs as at the end of each quarter.

Regional development workers (RDWs) will be aware of the position in each council area.

CAMHS partnerships will be completing their 2005-06 self assessment which covers each of the aspects of this PI.

The position in each council which has a Joint Area Review in the year will be reviewed along with other CAMHS data. **Using the scores on the 4 components to create bands for the PI**

This will be discussed with ADSS representatives on December 1st 2005 and councils will be notified as to the calculation as soon as possible thereafter, with information on other PI bandings for 2005-06.

Metadata

Coverage.Spatial	England
Coverage.Temporal	Start date of capture: 2005-09-01 End date of capture: 2006-02-28
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Date.Issued	2006-06-23
Date.UpdatingFrequency	Annually
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Format	Text
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About the Artists

We would also like to thank Simon, Lee, Ruth, Charlotte, Kirsty, Rebecca, Dale, Coleen and Jonathan for the artwork that has become the trademark for CAMHS mapping. They originally developed the work in 2002 when they were aged 8 to 11 years old. The children were from Easington, Derwentside, Durham and Chester-le-Street in County Durham. They made the figures while working in a group facilitated by Lynne Brown, a nurse at Chester-le-Street Health Centre. The aim of the group was to promote self-esteem through art and story telling. The figures were made of collage and were life-sized.

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School of Applied Social Sciences
Durham University
Elvet Riverside 2
New Elvet
Durham
DH1 3JT

email: info@camhsmapping.org.uk
web: www.camhsmapping.org.uk

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